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EDITORIAL

A GOOD DOCTOR IS A GOOD CITIZEN

The physician who consistently fails to attend hospital staff meetings, or who takes no active part in the affairs of his Medical Society, is hardly in a good position to criticize either the hospital or the Medical Society. By failing to make his voice heard, he must share the blame for any faults, failures or deficiencies.

Likewise, the physician who fails to *register* and *vote* is not in a good position to complain about corruption, taxes or Governmental policies which he finds obnoxious. By failing to fulfill one of the vital duties of citizenship, he must share the blame for any black spots in the affairs of the community, the State or the Nation.

The right to *register* and *vote*, which is both a privilege and a duty in a Nation of free men, was never more important than it is right now. Fundamental issues which transcend the usual party politics, and which will affect the future of every American, call for a clear-cut decision by the entire voting population. Be sure that you play your rightful part in that historic American decision.

To be a good doctor—first be a good citizen. *Register* and then *Vote*. And of equal importance, see that your family does likewise.

DON'T BE DERELICT!

The late Justice Oliver Wendell Holmes once said that a man must take part in the action of his times, lest he be judged not to have really lived.

In this critical election year of 1952 we might paraphrase that statement to say that every physician must register and vote, lest he be judged derelict in his duty as a citizen.

The vast majority of physicians are deeply conscious of their responsibilities in the care of the sick and injured. It is imperative now that they become equally conscious of their high duties as American citizens. This year of decision on vital issues requires the fullest possible expression of opinion by the largest possible number of qualified voters. Physicians, as members of an educated, thinking, professional group, must help set an example to bring that about.

So, regardless of your political viewpoint or party affiliation, *register* and then *vote*—and urge your family, friends and patients to do likewise. This is a duty which you owe to your profession, to your community and to your country. *Don't be derelict in that duty*!

Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer met in the Small Hall of the Medical and Chirurgical Faculty Building on February 21, 1952, from 5-6 P.M.

CASE DISCUSSIONS

Case I. Discussion of this case was deferred until the next meeting as the physician concerned was ill and unable to attend the meeting.

Case II. E. J. Colored. Age 50. Married. Para 5, 1 miscarriage. Beginning about September 1951, excessive flow at time of menses and intermenstrual spotting. Bleeding later became almost continuous. Consulted doctor A, October 1951:—was given oral medication and "needles" once a week for several weeks. Hospitalized January 1952, for D. & C. Biopsy showed carcinoma and patient was referred to second hospital for treatment. X-ray. *Diagnosis:* Squamous cell carcinoma of cervix, I. C. III a.

Chairman: Doctor A was unable to attend the meeting today but we have received the following information from him: "This patient was seen on the 24th of February 1951 with the complaint of menorrhagia of two weeks duration. She was given 40,000 units of estrogenic hormone and an RX for diethylstilbesterol, 5 mgm. t.i.d., tablets 12, and told to return for a pelvic examination as soon as she stopped bleeding. She returned on May 19, 1951, with the same complaint of menorrhagia of two weeks duration. She was advised to come back as soon as she stopped bleeding. She returned on the 31st of May 1951. At that time speculum examination revealed a small suspicious area on the cervix and the uterus was slightly enlarged. Hospitalization for biopsy and D. & C. was advised, but refused. She was seen again on November 21st, 1951 for La Grippe. Fluoroscopy at that time revealed a tumor mass in the right chest. Patient said that she knew of this for the past two or three years. She received penicillin on the 29th of November, 6th of December and the 24th of December, 1951. She returned on January 9th, 1952, again with the complaint of menorrhagia. She was advised to go to the hospital and was hospitalized on the 15th of January, 1952. At that time biopsy of the cervix revealed carcinoma. She was referred to another hospital for radium therapy."

This physician seems to think that bleeding is a contraindication to a pelvic examination. To my mind this is no reason for postponing an examination. It is often the best time to examine a patient in order to determine where the bleeding is coming from. In this case the complaint was irregular and excessive bleeding and a pelvic examination was indicated whether or not the patient was bleeding.

Is there any discussion of this case ?

Committee member: Was radium used in the treatment of this patient ?

Committee member: Not to date because of the terrific extent of infection.

Committee member: Here again we have a case of a patient being treated with estrogenic hormones and a pelvic examination not done.

Chairman: This would seem to be a case of physician delay because a pelvic examination was twice deferred because of bleeding. There was also obvious patient delay.

Case II—Patient and physician delay.

Case III. M. K. White. Age 69. Widow. Para 5, two miscarriages. Menopause between 55-57 years of age. Many episodes of cystitis over the past four years. Occasional spotting over the past two to three years. During this time under care of doctor A, for treatment of hypertension and frequent bladder symptoms. Pelvic examination said to show an "irritated place on cervix"—biopsy not taken. Consulted doctor B, August 1951—was examined—referred to hospital clinic and hospitalized. *Diagnosis:* Squamous cell carcinoma of cervix, Stage I. Treated with radium and x-ray. Readmitted to hospital January 1952, with complaint of abdominal pain and distention. Operation: Exploratory laporotomy—Choledocholithotomy—Biopsy of liver. Biopsy of the liver showed liver involvement.

Chairman: We are sorry that doctor A is unable to be present today. By telephone we have received some notes from his records on the patient. He has seen this patient at fairly frequent intervals over the past several years. The patient's chief complaint was hypertension and she also had many episodes of cystitis. I.V. pyelograms in 1949 were negative. Pelvic examination was made November 18, 1949, when patient complained of vaginal bleeding. This examination said to be negative except that the cervix bled easily. D. & C. was advised but the patient did not wish to have this done. Douches were prescribed. When the patient was seen in January, 1950, she stated that she had had no further bleeding and she was not again examined. The patient continued to consult doctor A at rather frequent intervals—the last visit on July 6, 1951, with a complaint of cystitis. There was no further note of complaint of vaginal bleeding; no pelvic examination except in November of 1949.

Committee member: This is the second case we have had where D. & C. was recommended but refused by the patient. This seems to bring up the question of how strongly the D. & C. was, or should be, urged. If a patient is made to realize that this is important, not many of them will refuse.

Chairman: Certainly it is a rare thing for a woman on whom I have recommended a D. & C. to refuse. Once in a while a woman will say it is not convenient, etc., but an explanation, increasingly blunt if necessary, will usually persuade her to have it done.

Visiting surgeon: I would like to ask if there was any contraindication to a Wertheim in this case ?

Visiting surgeon: Yes, the patient was obese, elderly and hypertensive.

Chairman: I believe even Dr. Meigs would consider this sufficient contraindication to a Wertheim.

Visiting surgeon: This case was interesting to us for several reasons. When the patient was first seen in August the lesion appeared to be entirely confined to the cervix. She was treated by two insertions of radium, followed by deep x-ray. She appeared to have a very good result. She returned to the hospital in January with acute pain and a mass in the upper right quadrant. It was decided it was necessary to do an exploratory laporotomy. At this time the pelvic organs felt normal—we were unable to feel any involvement and no palpable glands. Liver biopsy taken at this time showed carcinoma compatible with the original carcinoma. Although the classification was originally Stage I, as it developed it should have been Stage IV. Even at the time of her admission to the hospital in January, the cervix showed no evidence of recurrence.

Chairman: This is another case of a hypertensive patient with vaginal bleeding. There is a good deal of mention in the British medical literature of so-called "apoplexy of the endometrium." Whether or not in this case it was considered a possible cause of the bleeding we do not know. I do not put much stock in this and certainly no doctor should assume that bleeding is due to hypertension. In one study that was made of unexplained post-menopausal bleeding the suggestion was made that hypertension might be an explanation. On looking over the histories I found the average blood pressure was below normal in all of these cases.

There was some discussion of hypertension and vaginal bleeding, and whether or not this was a category in which patients could be classified when vaginal bleeding seemed otherwise unexplained.

Chairman: It seems that we cannot rule this case physician delay because a D. & C. was suggested and refused.

Case III—Patient Delay.

Case IV. E. R. White. Age 54. Sep. Para 8. Menopause at 38 years. June 1951, patient noticed slight bleeding which she thought was from hemorrhoids. At this time she was under care of doctor A regarding "lump in throat." Told him of the bleeding—was given salve for hemorrhoids but was not examined. Hospitalized August 1951, for excision of submaxillary gland, left, for calculi with infection. Routine physical at that time noted "small bleeding point on anterior surface of cervix"—"cervical bleeding should be looked into." Discharge summary August 27, 1951 notes "pelvic essentially negative except for cysto-urethrocele and rectocele." Referred from surgery to gyn. clinic September 12, 1951—hospitalized September 17, 1951. Radium and x-ray. *Diagnosis:* Epidermoid carcinoma of cervix, I. C. Stage I, early.

Chairman: Although this patient's complaint was bleeding "she thought was from hemorrhoids," she should have had an examination. A patient often does not know whether she is bleeding from the vagina or rectum. In either case an examination is indicated. When in the hospital the patient was on the surgical service and although it was noted that she was having vaginal bleeding there was no gyn. consultation. The patient was referred to the gyn. clinic after her discharge from the hospital.

Committee member: There was actual delay here of only two weeks from the time the patient was examined in the hospital and the time she was referred to the gyn. clinic. By a technicality the surgeons get under the wire because of our arbitrary ruling of "delay" as a lapse of one month. Certainly a gynecological consultation should have been made on the ward before the patient was discharged from the hospital.

Visiting surgeon: This patient was admitted to the hospital for a minor operation. It seems to me the surgeons should be complimented for having done a pelvic examination in the routine physical.

Visiting surgeon: I would like to mention that every female patient (ward) coming into our hospital on the medical service is given a pelvic examination by a member of the gyn. staff.

Case IV—Physician Delay.

Case V. E. E. Colored. Age 28 years. Married. Para 0. October 1950, patient under care of doctor A because she was overweight. Pelvic examination made at this time; patient told she either had a tumor or was pregnant. Friedman test negative. Menses continued normal until March 1951, missed April and May and abdomen became very much enlarged. Consulted doctor A—was examined; was told he did not know whether or not she was pregnant. Because of differing opinions patient decided to go to hospital clinic June 1951. First seen in gyn. clinic, thought to be pregnant and referred to O.B. clinic where she was examined and told she was pregnant. Because of vaginal bleeding patient returned to O.B. clinic late in June. At this time it was decided that she was not pregnant and she was referred back to gyn. Medical work-up during July; admitted to hospital July 23, 1951. Laporotomy revealed extensive involvement of all abdominal organs; because of patient's condition it was not possible to remove pelvic organs at this time. X-ray treatments August and September. Operation January 1952: Panhysterectomy; bilateral salpingo-oophorectomy.

Diagnosis: Papillary carcinoma—ovarian origin (right)—metastatic.

Chairman: This seems to be a case where the patient was fighting to get a diagnosis. I do not believe we can be too critical of the men who saw the patient on the outside when there was considerable delay in getting a diagnosis after the patient came to the hospital.

Visiting physician: This case was particularly confusing to us because the patient's menstrual history showed that she had missed a period at various times. When seen on September 19, 1950 she gave a history of scanty menstruation for two days, then menstruation again fifteen days later, then at the time due again she had a regular period. At this time she was complaining of being tired and "let-down." Friedman test was negative for pregnancy. She went along normally until March but missed a period in April. On April 13, 1951, the uterus was slightly enlarged and she was complaining of pain in the right lower side with dysuria. I recommended bedrest for two to three weeks. When the patient was seen again I was still uncertain as to whether or not she was pregnant. The uterus seemed too much enlarged for the probable length of the pregnancy. Another pregnancy test was advised but this was not done. The patient then consulted another physician and was assured that she was pregnant. I did not see her again until after she had been to the hospital clinic and she came back to us because she was dissatisfied with the treatment she had received. I advised her to stay with the hospital. Frankly I did not know about this patient. The tumor did enlarge relatively rapidly and the growth was too fast for a fibroid.

Data was given from the hospital history and operative notes. Friedman test done in the hospital in June reported negative.

There was discussion of the difficulties in diagnosing carcinoma of the ovary—one of the doctors calling it "the biggest challenge in gynecology."

Visiting surgeon: Would you elaborate on your statement in regard to waiting in the case of adnexal enlargement ?

Chairman: If the enlargement is golf-ball size or egg-size and there is a question whether it is malignant or a retention cyst, you might follow this case for a time, possibly a month. If it is a retention cyst it will disappear. When you are sure you are dealing with a neoplasm of the ovary, you had better get in. If it is part solid and part cystic, you had better get in. If otherwise, you will be justified in waiting for a while.

The case under discussion is obviously one in which the diagnosis was difficult. We should consider whether or not the physicians did all that was possible in order to arrive at a diagnosis. The patient was first seen in the hospital on June 13, 1951 and was not hospitalized until July 23, 1951.

Case V—Institutional Delay.

Case VI. B. S. Colored. Age 49 years. Married. Para 0. September 1950 excessive vaginal bleeding for 2–3 days.

Following this menses more frequent—some intermenstrual bleeding and post-coital spotting occasionally. Consulted doctor A, September 1950. Pelvic examination was made. Patient told she had a "fibroid" and was beginning the menopause. Consulted this doctor about once a week. Was referred to hospital, December 1950. *Diagnosis:* Squamous cell carcinoma of cervix, Clinical Stage I. Radium and x-ray.

Chairman: A pelvic examination was made in this case but the presence of a "fibroid" does not explain the bleeding, especially with post-coital bleeding. We do not know what treatment the patient received, if any, while under the care of doctor A. It appears that further examination should have been made or the patient referred to the hospital. There is apparent delay of three months.

Case VI—Physician Delay.

Case VII. A. P. White. Age 38 years. Married. Para 2. Artificial menopause May 1944 (supravaginal hysterectomy). November 1950 patient consulted doctor A with complaint of dysuria and frequency. Pelvic examination at this time was negative. Cystoscopy revealed urethral stricture requiring treatment until March 1951. December 1951, post-coital bleeding. Consulted doctor A—was examined—hospitalized for conization of the cervix. Re-admitted to hospital December 31, 1951. I.V. pyelograms negative—x-ray examination of colon, negative. Attempted radical Wertheim January 9, 1952. Radium. To have x-ray following discharge from hospital. *Diagnosis:* Immature to medium ripe squamous cell carcinoma of cervix, Stage II.

Chairman: Is there any discussion of this case ?

Visiting surgeon: At the time of conization was the tissue examined ?

Guest surgeon: Yes. It showed immature to medium ripe squamous cell carcinoma. The further studies as indicated on the abstract—the I. V. pyelogram, x-rays, etc., were done in preparation for a radical Wertheim. At operation it was found that a Wertheim could not be done.

Chairman: Certainly there is no criticism of the studies done in preparation for a radical Wertheim but why should a radical Wertheim be attempted in a Stage II ?

Guest surgeon: It was felt that this was a suitable case. It was an early Grade II, the patient weighed ninety pounds, there was no evidence of metastasis and we did not expect too much technical difficulty in the operation. I feel that in selected cases Stage II's are suitable for Wertheim.

Visiting surgeon: Meigs states that the ideal radiation treatment is not yet found and so he attempts operative procedure. His reports are good on Stage II A (I. C.)

Committee member: Meigs' actual figure in Stage I, 85 cases, is 80%. Including Stage 0 cases it is 88%. Figures in the Stage II group (selected cases only) are in the 60's. If all Stage II cases were included the figures would be very different because there is a great difference in a Stage II where the tumor goes to the pelvic wall and in a II with a little extension to the vaginal vault. Our figures, including all Stage II's show about 40% salvage in II's treated with irradiation. It is difficult to compare figures because of difference in classification in different clinics.

There was considerable discussion of the Wertheim and Brunschwig type of operation. Those defending the radical operation pointed out that the doctors of today are able to do a more radical operation than in the "old days" because they have more to work with and more aides in the way of antibiotics, transfusions, etc.

The question was raised as to what should be done in the case of radio-resistant carcinoma. There was some discussion of cases and the consensus was that radio-resistant I's and a few selected radio-resistant II's were suitable for radical Wertheim operation.

Case VII—No Delay.

STATISTICS

Patients Interviewed to *February 19, 1952*	98
Classification:	
No Delay	29
Patient Delay	36
Physician Delay	10
Patient & Physician Delay	7
Institutional Delay	1
Patient & Institutional Delay	1
Asymptomatic Detected Cases	2
Unclassified to date	12
	98

NO LONGER OUR IVORY TOWERS*

NEWLAND E. DAY, M.D.

The "Great" of Medicine, in the past, were able to hold themselves somewhat aloof from the roar of currents and tidal waves that seemed sometimes to engulf the average laity, and yet pass by the profession with but a ripple of disturbance. There was a mystic relationship between doctor and patient, then, that had to do with roots of understanding; heritages of faith, that were based upon an almost unshakable belief (perhaps not always, but almost always justified) that "our Doctor" was infallible! In turn, the doctor could, in almost all instances where he had shown good faith, count on the loyalty of his people, and know that, when the "chips were down," he and his patient stood shoulder to shoulder against forces of evil seeking to destroy that bond. His patients deserved the best he could give them regardless of their ability to pay. Public appreciation of that relationship and of his status in his community thereby was a form of compensation that kept a doctor from feeling the rub of poverty even when he lived with it and in it. He was therefore less perturbed by the surge of economic and political forces than had he been engaged in some other profession.

But time and events have forced doctors to take another look at themselves and their relationship with their patients or "public"! Though the doctor has been content to drift along wearing the time-honored medallion of "Public Service," unaware that the shine of past services is becoming dulled by carelessness, political and economic winds have arisen blowing an increasingly corrosive dust to dim that medallion in the public eye. An era of discontent has begun and the intangibles of public service are no longer mentioned. "Great Words" are being used (or misused to suit the purpose) to introduce a radical change, from those philosophies which have made this Country great, and which are symbolized by the statement that "Man lives not by bread alone," to blunt National policies that scoff at this and say "Man Does Live By Bread Alone." An attempt has been made to reduce our nation to that animal status under which the one factor of importance is "our bread" and under which nothing else matters. This is a state in which the individual's income will be determined by his needs rather than by his contributions to society.

The shock of "The Depression" failed to make doctors aware that they were no longer protected by an "Ivory Tower" from the twists and turns that men's minds will take when hunger is astutely used as a lever. Nor did they realize that the fear of illness and its costs plus the panic of unemployment was being used to threaten man's very sanity.

Caught up in the pre-war and wartime urgency of "a big job to be done," doctors became too busy to notice that these forces had never let up but that the strangulating net was being drawn tighter over everyone in the guise of patriotism, and that every time he became careless or indifferent to the financial problems of his patients he was helping his detractors carry out their "plans of organization."

About 1948 doctors awoke with a start to the realization of what was transpiring and with some of the panic which they had sometimes failed to recognize in others. No longer were there innuendos suggesting that a change was going to be made. Now there were front page pronouncements that the National Administration had committed this Nation in its platform to a program of compulsion comparable only in its scope to those established in completely totalitarian, collectivized countries. Guess who was involved this time! Though it had been going on all around him: public utilities, the farm, etc., socialistic tentacles were reaching for the doctors. "Ivory Towers" no longer appeared to be a haven for retreat, but rather had become a target for the malicious who charged that the Towers of Medicine represent not "service but whitewash."

However doctors come in daily contact with, and are inherently geared to deal with crisis, and indeed are apt to function better once they realize what the crisis is about or that one exists.

Let us see what has been done since 1948, as manifestation on the part of doctors that they must

* Submitted by the Committee on Public Medical Education, Baltimore City Medical Society.

re-establish a satisfactory doctor-public (patient) relationship. How can the doctor be accorded that respect so essential to the successful conclusion of his professional duties? What has happened to permit a closer and warmer contact with the patient and to make the patient realize that he and his doctor still do have a common heritage of faith? What has renewed the belief that "that nation is governed best that is governed least"?

Doctors again have become citizens! They have recognized and are using the power of Truth. The narcosis of the sedative administered by the proponents of "Free" or Compulsory Medicine could only be overcome by the powerful stimulant of "Truth." So doctors have taken the true story to the Nation. When they began, only one organization was on record in Congress as being against Government Medicine. Today, over 15,000 organizations representing millions of people have thrown down the gantlet of protest in such a way that even the most power-hungry cannot overlook it.

Having become civic conscious, we realize now that this is not just a fight of the profession for itself, and not just a fight against a system of foreign instigated compulsion. We must re-educate the public to the fact that the American Medical Profession maintains a constant vigilance over the Health and Welfare of our nation in a manner to guarantee their *protection* and not their subjugation. We must point out the fact that a GREATER EXTENSION OF VOLUNTARY MEDICAL CARE GIVES A MAN PROTECTION BUT LETS HIM KEEP HIS PRIDE. We in Maryland, under the sponsorship of The Faculty initiated a program for the care of the "Medically Indigent."

Concentrating on the problems of the most needy, caused some delay in tackling the problems of the so-called middle income or white collar groups. The latter groups are now protected against catastrophic illness along with the lower income group through the extension of Blue Cross and Blue Shield or Medical Service programs.

Public service and public relations have been improved through the establishment of city, town and country *Emergency Medical* Services or Emergency Call Exchanges. The lack of any such organized program had previously been a source of public irritation which had been increased by a few unfortunate circumstances attracting bad publicity. This service may stand us some day in great stead in the event of public disaster.

A Faculty grievance committee has been established. The existence of such a committee has helped to raise the public estimate of the value of this State Society. In connection with this service, our Committee for Public Medical Education recommends wider publicity on the existence and work of the State Committee on Professional Conduct.

In cooperation with the Committee on Public Medical Education the Woman's Auxiliary to The Medical and Chirurgical Faculty has been most active and has manifested limitless energy in its support of the fight for Medical Research popularly known as the "dog fight." The Auxiliary has had Health Booths at County Fairs, etc., in support of the "American Way of Life" and have supplied excellent speakers for various occasions. In addition, it has spread an enormous amount of good will for the profession as an organization interested in health problems.

Finally, the American Medical Education Foundation, of which there is a local cooperating committee, is one more proof positive that the doctors are working to assure a sound doctor-public relationship, as well as a supply of young doctor graduates from academically free institutions of learning.

NEED FOR PHYSICIANS

A survey shows that the 65,000 people of Frederick County are dependent on no more than 20 resident physicians in general practice. Officers of the Frederick County Medical Society composed a Steering Committee, which has made a detailed study of the availability of medical care at present and in recent years. Added to the 20 general practitioners living in the City and County, the report stated that there are 10 more from borderline communities and other counties, who use local hospital facilities and number some Frederick Countians among their patients.

Scientific Papers

THE PHYSICIAN AGAINST ATOMIC ATTACK[1]

WILLIAM L. WILSON, M.D.[2]

Wherever one turns, varying degrees of anxiety exist over the possible lack of reasonable security against threats of atomic attacks by an enemy, with or without a warning to the population. Whether or not such a fear may be justified, that our cities might be subjected to atomic or other modern attacks, cannot be asserted positively. Nevertheless, the potentialities are known to be present. What is sure is that people have always accepted such a challenge to their survival in the past. They have met with relative success in their efforts towards that survival. However, now as in the past, people have a right to demand and must have proper leadership for their efforts. There is nothing new in this situation due to atomic bombs.

Someone has said that twenty-three hundred years ago Aristotle wanted a city of a type where one could work effectively and which would be hygienic, attractive, and readily defended. How little some circumstances have changed! But how much others have started us on a tight-rope race for survival! Two recent world conflicts have been decided favorably by this Nation, where people could work effectively, where our industrial production supported our own and allied fighting forces in such a manner as to make our cities readily defended, hygienic and attractive. American people may continue to work effectively, but only if their cities may be readily defended in the future. That is why a future enemy likely would strive initially to cripple American industrial production by all-out direct attacks upon our cities. Therefore, if we should not make our cities as easy as possible to defend readily, citizens could not work effectively during and after attacks, the cities would not be attractive, and they probably would not be hygienic. One must agree that a sense of some readiness for defense would promote mental health for workers whom we would ask and expect to continue on the job despite enemy attacks or threats.

Our own recent Federal Civil Defense Act of 1950[3] reiterates the age-old truths just mentioned. It defines "civil defense" in a manner indicating the priorities to be given to minimizing the effects upon the civilian population caused or which would be caused by an attack upon the United States, to dealing with immediate emergency conditions which would be created by such an attack, and to repairing or restoring vital utilities and facilities destroyed or damaged by any such attack. A physician should and does sense immediately his potentially essential part in the survival of the Nation if attacked.

Human life and productive skill cannot be replaced readily. This is a matter of major importance to us where the numbers of our people are limited, where their skills increase and capabilities are highly specialized only after long, carefully directed training, and where they are concentrated into densely populated areas of unbelievable vulnerability to attacks. Other nations of more people, less skilled, carry less risk. As critical as material damage to our cities could be, under the circumstances, the truly precious factors which we must preserve are life, health

[1] William Royal Stokes Memorial Fund Lecture, presented under the title of "Bulwark of the Nation—The Physician Against Atomic Attack," at the Annual Meeting of the Medical and Chirurgical Faculty, April 24, 1951.

[2] Colonel, Medical Corps, United States Army, Special Assistant to The Surgeon General.

[3] Public Law 920, 81st Congress, 2d Session.

and effective production. The immediate, deepest and most understandable concern of all of us in the presence of a disaster would be for the health and safety of our wives, children, loved ones, relatives and close friends. Maintenance of full civilian industrial support of a future war effort therefore depends upon our ability to preserve maximum physical and mental health of civilians or restore it where interrupted. That is why the physician is the bulwark of this Nation, why the physician has been, and must continue to be, a leader in every community preparation for survival from any damage an enemy could devise or direct against us.

Physicians may have pardonable pride in their past foresight leading to medical preparations for atomic attacks, preceding non-medical preparations of others in this country. Eleven years ago it was civilian physicians who first foresaw the need for a national civilian medical organization to care for our own civilians if subjected to enemy attack. Nearly five years ago, when others were not actively engaged in such matters, one of our highest military medical authorities sponsored development of national methods for integrating military with civilian administration of health services of the Nation for war, if it should come. Four years ago, the medical profession established the Council on National Emergency Medical Service of the American Medical Association leading to prompt, earnest development by the profession of methods by which physicians could support the Government in a National emergency. Soon after that the Public Health Service and State health authorities undertook the problem with equal confidence and ability. More recently, physicians grouped or banded together in practice for great good, have aligned thousands of citizens, or prepared them for aiding, in civil defense operations. As an example, physicians of one of our church denominations have initiated an organization and the training of its whole membership, while the Medical Correctional Association, through the American Prison Association, has stimulated a civil defense program for many thousands of prisoners. We need go no further to substantiate medical leadership of the past in developing community civil defense.

Immeasurable future contributions of time, thought and effort, and many and great additional sacrifices by the medical profession will be required, if physicians are to maintain necessary levels of health in the population they have always served so faithfully. It is readily understandable that the questions most physicians want answered now involve the manner in which they may serve, and when and where. These are questions which will not be answered in detail at this time by one individual, governmental agency, or group. They are questions the answers to which are influenced by every family and every home. The medical profession cannot solve the problems alone. Nevertheless, physicians can, and their leadership must, participate in the solutions while and as they are being developed, in order to maintain the health of the family and the significance of the home to the maximum practicable degree. Community physical and mental health, along with a desirable level of moral standards depend upon this, the public's confidence depends upon it, and desirable social effects of our preparation for civil defense, as well as any operations which might be required in the future, depend upon it.

At this time physicians do not need and, therefore of necessity should scrutinize, any detailed organization, manning and equipment specifications and prescribed procedures which would be forced upon them. Indeed, in the preparation phase for civil defense, the Federal Act depends upon voluntary participation by all citizens, in their own communities. Without this, the law alone cannot produce success. Wherever he has not already done so every physician should do four things:

1. He should learn the law.
2. He ought to search out and learn the local overall organization, its direction, and its nature, for civil defense.

3. He should join in local professional development of civil defense medical plans commensurate with the local overall plans.
4. Finally, through the professional organizations of the communities' physicians he should contribute to the development of Federal, State and local medical civil defense, and to its support by aiding in recruiting and training countless thousands of non-professional volunteers, without which medical success is unlikely.

In recent months it has been stated frequently that physicians are so far ahead of others in civil defense that they can do little now except wait for detailed manuals or additional guides in order to organize medical units. Nothing could be more short-sighted, or further from safety if such a concept were to be accepted. Federal guides and manuals will be developed and promulgated. But, they should be prepared only after all-round consultations leading to proper relationships visualized by the Federal Act to exist between Federal, Regional, State, and local authorities and between various civil defense services. The physician must understand not only these relationships but also the timing of measures to be undertaken, as well as the phase applicable at any one time. The law defines the measures to be taken in preparation for anticipated attack, during attack and following attack, as it does also organizational equipment, materials and facilities. Thoughtful persons will realize that local application of these concepts according to a national pattern cannot and must not be achieved over night by so complex a social order as ours is, unless we are to accept potentially undesirable or even irreparable damage from ill-advised and stop-gap social policies.

Once we understand our respective missions all of us must follow a uniform program in our development of plans. It is true that the uniformity must follow a leadership of National origin. As we desire such leadership we must recall that this was established by law less than four months ago. As we wait, we may gain confidence, no doubt, in the fact that a logical sequence of projected events can be set up along with dates for their anticipated accomplishment. The recent and new civil defense law provides for Federal coordination and guidance, for operation of the Federal Civil Defense Administration, and for prescribed necessary assistance. The Administration rightfully may be expected to suggest organizational structure and staffing patterns; objectives and their priorities; material means and their proper sources of origin; operational programs; training means and measures in technical, administrative, managerial and functional aspects of all programs; uniform standards of measurement of performance; but above all, an integrated, multilateral system of controls developed through a consultative participation by physicians. To achieve all of this, patience, tolerance and friendly joint exploration of all of our problems will be essential. In this most difficult phase of all, namely the preparation phase for civil defense, we cannot do without a sense of humor and a penchant for endless work. That work must be contributed by the profession, by the Federal, State and local governments, and by the public.

Physicians have not exhausted existing sources of new knowledge pertaining to civil defense. This is particularly true in technical aspects of modern weapons. There are sufficient references, training courses for key instructors, and training aids available to permit a wider spread of technical knowledge of the modern weapons and their effects, as they might be directed against civilians. Such training of the entire profession need not wait upon additional guides of any nature. In addition, many references are available to permit individual and group study of various possible organizations which would improve our general administrative knowledge and future performance, regardless of the uniform pattern for units ultimately to be proposed in Federal manuals. If the medical leadership does not engage in such studies and does not stimulate and initiate them, but should limit itself entirely to details of a few manuals of the future we

shall have something less than the medical success we have a right to expect. At the same time knowledge is being increased through conferences, study groups and society journals; the advice so necessary to have from the profession to planners for the different governmental agencies will become available.

You might gain confidence in knowing that in the Federal Civil Defense Administration, medical objectives and priorities have been defined and the dates by which we hope to achieve them have been set. It is anticipated that major objectives for the "preparation," "during attack" and "following attack" phases may be defined with reasonable rapidity and transmitted to regional, state and local civil defense offices. They may be furnished also to professional societies, scientific groups, and voluntary agencies; to all Federal agencies with a view to maximum, coordinated utilization of already existing resources; and they may be provided to individuals, families, and groups. At the same time, programs will have been scheduled in a systematic and orderly manner, with priorities, for the provision of material means; for the promulgation of organizational structure, staffing patterns and procedures, measures and activities; for specific training programs; for procedures and methods for measuring the levels of performances; for developing control systems, integrating them with other services of civil defense and for forecasting, promulgating, developing and distributing uniform technical information, guidance and policy. The medical motivation for all of these matters is established and appreciated by the Administrator, Federal Civil Defense Administration.

As a profession we may not be content until equal and better establishment of all of these programs will be initiated by state and metropolitan civil defense organizations, where civil defense ultimately must be made to work. It is your privilege to assure their existence and acceptability. Until all of us do that, we cannot visualize safety for most of our homes, for a public confidence that we have assured that all hazards of physical, mental and moral origin will be overcome; and that true community health will survive all such hazards.

In signing the Federal Civil Defense Act the President of the United States said, "It (civil defense) will require the best efforts of all of us to get ready . . . to defend our homes. No true American would want to give less than his best to that cause"—It goes without saying that the physician is the bulwark of the Nation in that cause. The physician will accept the drudgeries, the frustrations, the occasional impatience of himself and his brothers because of seemingly unsatisfactory progress in civil defense. He has earned this place by his intimate part in attending the birth, prolonging the life, and delaying that ultimate day of death of every member of the home. He has earned his place because of full knowledge that as the bulwark of the Nation against atomic and all other attacks he will furnish the best medical care any population ever had, so long as his own medical leadership exists in good conscience as "the best efforts of all of us."

The physician may be compelled to do this with insufficient means; with nothing more than he has immediately available wherever a disaster might occur. He will be forced to give only mass attention and treatment to injured thousands, instead of the near ideal treatment of an individual physician-patient relationship all of us eschew so properly. He will be obliged, in the common good and for the sake of National survival, to sort patients in an entirely impersonal manner and without regard to the order in which they came under his medical surveillance. The patients themselves and their families and loved ones, will understand and desire that all of this be done if physicians will have previously informed and educated the public through channels and by techniques already available to us. This will require the most careful and uniform efforts of practicing physicians and health de-

partments, determined and followed by them jointly.

When each physician will have participated wholesomely and cheerfully in a manner somewhat similar to all that we have just considered, then, and perhaps only then, can he realize in the words of Ruskin, his true goals of preserving the American home:

> "This is the true nature of home—it is the place of Peace; the shelter, not only from all injury, but from all terror, doubt, and division."

CORTISONE (CORTONE) IN THE TREATMENT OF ACUTE SUBDELTOID BURSITIS

MARION FRIEDMAN, M.D.

Since the isolation of cortisone and ACTH much effort has been expended in attempting to determine in what diseases or conditions they might be useful. If the manner of action of these materials were known, a more logical approach toward their employment could be undertaken. At this time we can only assume that their action is not on the etiological irritant but on the tissue reactions to that irritant.[1] For this reason, and as a result of numerous clinical empirical trials in a wide variety of conditions, it has become increasingly clear that their greatest therapeutic promise seems to be in acute or self-limiting diseases.[2]

Acute subdeltoid bursitis is an inflammatory process of the bursa produced by trauma or infection, causing severe pain, tenderness and limitation of motion. Some of the pain and limitation is produced by the associated spasm of muscles surrounding the shoulder girdle. When the disease becomes chronic, further difficulty is caused by the production of villi within the walls of the bursa, with ultimate calcium deposition, and by the development of adhesions.

Treatment, for the most part, has not been entirely satisfactory. Certainly immobilization, local forms of heat (or cold), diets, analgesics, injections of novocaine and operation are not desirable therapy if there is available an oral medication which reduces the period of disability to a fraction of its previous length. While the use of x-ray therapy has provided much benefit to many sufferers, its drawbacks include cost, length of treatment, period of disability and pain between treatment and effect, and failure to prevent calcium deposition in the bursa.

To date no case reports concerning the use of cortisone or ACTH in the treatment of acute subdeltoid bursitis (or bursitis in any other site) has appeared in the literature. Only two very brief notes have given passing attention to the problem. At the International Congress of Internal Medicine it was reported, "Lately it has been used in toxemia of pregnancy and in subdeltoid bursitis."[2] There was no further elaboration on this point. In describing the effects of cortisone and ACTH on rheumatoid arthritis Boland states, "non-articular features, such as subcutaneous nodules, enlarged lymph nodes, bursites and tenosynovitis improve or disappear along with improvement in the joints."

The author has recently had the opportunity to administer cortisone orally to three individuals with acute subdeltoid bursitis. It is believed that the results are impressive.

Case 1. G. B., a 46 year old white housewife, was seen on October 14, 1951 because of severe pain and limitation of motion of the right shoulder of three days duration. The pain was so severe that she had not slept for two nights.

This patient had on two occasions between 5 and 10 years ago been hospitalized for a mental illness characterized by depression. About two years ago she had been treated by the writer for a mild depression without hospitalization. History was not otherwise significant.

Examination revealed the right arm being held in forced adduction with spasm of all muscles about the shoulder girdle. Pressure just below the acromion over the deltoid muscle with the arm by the side produced exquisite tenderness. When the arm was abducted to a right angle, pressure over the same area caused no discomfort. Analgesics, immobilization, heat and anti-spasmodics were used for five days without improvement. Her only relief during this time was obtained in brief periods of about two hours after taking codeine sulfate.

The patient was placed on 100 mgm. of cortisone (cortone) orally every 8 hours on the first day, 100 mgm. every 12 hours on the second day and 50 mgm. every 12 hours thereafter until 1 Gm. (forty 25 mgm. tablets) was administered. When cortisone (cortone) was begun all other therapy was discontinued, except that the patient was allowed to use analgesics. She was permitted to move the arm at will. Definite easing of her pain was noted 8 hours after the first 100 mgm. and before taking the second dose. At that time she began moving her arm voluntarily. Within 48 hours all pain, local tenderness and limitation of motion had disappeared and all analgesics were voluntarily discontinued. It was not known how long therapy should have been continued, but the patient was advised to complete the tablets on hand as described above.

She has remained entirely asymptomatic after three months without further treatment. X-rays at that time revealed no evidence of calcareous deposits in or about the bursa. About one week after cessation of cortisone the patient became mildly tense and somewhat depressed but required only mild sedation.

Case 2. M. B., a 32 year old white female, was delivered of twins on November 19, 1951. She had developed a toxemia with rising blood pressure, 2 plus albuminuria, slight ankle edema and rapidly increasing weight. Labor was therefore induced three weeks prior to her expected date of confinement. Twelve days after delivery she developed severe pain, tenderness and limitation of motion in the left shoulder.

Examination two days later revealed findings similar to those noted in Case 1. The patient was placed on cortisone (cortone) orally, using the same regime previously employed. No other therapy was used during or prior to the administration of cortisone (cortone) except that she was allowed analgesics as desired for the first two days. Again there was notable relief in 8 hours and complete remission of the process in 48 hours. During therapy the patient gained 5 pounds and developed mild ankle edema. Her urine and blood pressure remained normal. With cessation of therapy the edema subsided.

There has been no recurrence of symptoms. X-ray examination two months later revealed no calcification in or about the bursa.

Case 3. H. T., a 42 year old white housewife, was seen on January 28, 1952 because of severe pain in the left shoulder with associated limitation of motion of two days duration. She had been unable to sleep the night before because of pain.

Examination revealed findings about the shoulder similar to those previously noted. She was placed on cortisone (cortone) orally using the same regime already described except that no analgesics were administered concurrently. Within eight hours there was noticeable diminution of pain. After 36 hours she was able to voluntarily raise her arm over her head although it produced some moderate degree of pain. After three days she was well except for mild pain in the shoulder on motion and mild tenderness to pressure over the bursa. These residual symptoms were still present when she had used the last tablet (a total of 40) but had disappeared two days later, or nine days after therapy was begun.

COMMENT

The rapid involution of the acute bursitis in two cases treated with cortisone (cortone) and the somewhat less rapid recovery of a third, while not unequivocal evidence of its value in all such cases, would suggest that further studies along these lines are indicated. It is quite possible that one-half to three-quarters the dosage used here would have been equally efficacious in the first two cases. In the two cases which responded rapidly, analgesics were also used for the first 48 hours. In the third, where involution was somewhat slower, analgesics were not employed. Whether or not this was coincidental would seem to justify further study.

It is also probable that cortisone (cortone) prevents deposition of calcium in the bursa and adhesions about it. The rapid involution of the process under cortisone (cortone) therapy would seem to be responsible for this phenomonon.

The appearance of mild adverse side-effects in the first two cases is of interest in that it has become well recognized that cortisone (cortone) and ACTH tend to produce these in many persons who previously sustained mental illness and kidney alteration. Nevertheless, the period of therapy appears so brief that these conditions are not regarded as sufficient contraindications for most persons.

SUMMARY

1. The use of cortisone (cortone) in the treatment of three cases of acute subdeltoid bursitis is described.

2. The possibility that this mode of therapy prevents calcific deposition in the bursa and adhesions about it is suggested.

3. These cases are presented to stimulate further study along similar lines.

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THIRTY YEARS OF PHYTOPHARMACOLOGY OR APPLICATIONS OF PLANT PHYSIOLOGY TO MEDICAL PROBLEMS[1]

DAVID I. MACHT, M.D., F.A.C.P.

This is a survey of thirty years' research work already published and an announcement of several new investigations in progress in a new field of biology. Thirty years ago the author who was then associated with the late professor John J. Abel at the Medical School of the Johns Hopkins University conceived an idea to compare the pharmacological action of drugs and poisons on animal tissues and protoplasm with the action of the same chemicals on vegetable tissues and protoplasm.

Pharmacology taught in medical schools usually deals with the effects of drugs on animals and is strictly speaking Zoopharmacology, and as Physiology medical men usually understand Zoophysiology or the effects of drugs on animals. There is a most important field of biology known as plant physiology or Phytophysiology. The author has attempted to develop a field of Zoo pharmacology, and he has spent considerable time in the laboratories of the late Burton Livingston the eminent professor of plant physiology at Johns Hopkins.

Many methods may be employed for studying the effects of drugs or chemicals on plants. Among them may be enumerated the following: germination of seeds, growth of roots and stems, growth of yeasts and molds, oxidation-respiration phenomena, respiration, transpiration, metabolism in general, vernalization, photosynthesis, etc. A most convenient and practicable method employed by the author is the measurement of root growth of seedlings of *lupinus albus* in hydroponic solutions under exact ecological conditions of light, temperature, etc. In this way many pharmacological studies have been made and published on all kinds of chemicals and drugs such as: organic and inorganic mercury compounds, series of alcohols, chemical isomers

[1] Department of Pharmacology Research Laboratories, Sinai Hospital, Baltimore. Read before Section G of AAAS, December 29, 1951, Philadelphia, Pa.

of menthol, amino acids, cardiac glycosides, snake-venoms, sulfa drugs, etc. The most important findings, however, from a medical point of view have been in experiments with different blood sera and other body fluids. Inasmuch as it was discovered that chemicals as drugs derived from the animal world were usually and relatively more toxic for plants than for animals, it was thought worthwhile to employ a phytopharmacological approach to the detection of substances in the blood which have hitherto not been demonstrable by animal experiments and even by ordinary chemical tests.

By accurate quantitative experimental methods the author has demonstrated the presence of a toxic substance—menotoxin—in the blood serum, sweat, saliva, milk and other secretions of menstruating women. By similar methods, it was established that in pernicious anemia and not in any other kind of anemia or leukemia there is another toxic substance in the blood which is different from menotoxin. Further experimentation revealed characteristic toxic reactions on *lupinus seedlings* by the blood sera of *trachoma* and *leprosy*. A very extensive research on a highly fatal skin disease *pemphigus* has been conducted by the writer and the late dermatologist Isaac Pels. It was found that this particular skin disease and no other with the exception of leprosy gave a characteristic phytotoxic effect which is now extensively employed by the writer for the diagnosis of pemphigus and for the evaluation of various methods of its treatment. It was further found that the toxin of pemphigus can be destroyed or antagonized by irradiating specimens of the serum with certain X-rays, and later it was found that ACTH and cortisone in minute quantities also neutralize the pemphigus toxin in vitro. These same findings have been confirmed clinically. More recently the author has been engaged in the study of the blood in individuals suffering from psoriasis. It was discovered that psoriasis like most other dermatoses did not inhibit the growth of the lupinus seedlings, but by the employment of specially treated plants it was found that psoriasis gives a specific phytotoxic reaction which is both of scientific and practical diagnostic interest.

Perhaps the most important contribution of phytopharmacology with the exception of the work on pemphigus has been the result of a twelve year investigation by the writer and his collaborators on the blood of mental patients. This research in which approximately 1400 specimens of blood serum from different hospitals have been examined led to the following conclusions:—All true psychoses whether so-called "organic" or "functional" exert a definite phytotoxic action on the root growth of lupinus albus seedlings reared under normal laboratory conditions. The degree of toxicity varies quantitatively not so much with the type of psychosis—whether melancholia, mania, depression, schizophrenia, paresis etc.—but with the degree of the severity of the disease. Similar phytotoxic reactions are exhibited by the spinal fluids of psychotic patients. This phytotoxic reaction is valuable in diagnosis of doubtful cases of psychoses. It also offers a criteria for the evaluation of therapeutic measures, and obviously may be of medical legal interest. Strangely enough bacterial infections give no phytotoxic reactions. On the other hand, lupinus seedlings can readily detect carbon monoxide in the blood and actually demonstrate the effects of stray x-ray waves in the blood of radiologists and their staffs.

In addition to the work on psychoses and pemphigus which is still continuing, the author is now engaged in investigating two other important pathological conditions by a phytopharmacological approach. While most bacterial infections and viral diseases yield no phytotoxic effects as compared with normal human blood serum, it was thought worth while to inquire into the influence of syphilitic blood on special plants. Syphilitic blood serum and spinal fluid do not produce any inhibition in the root growth of normal seedlings of lupinus albus and in fact, are usually even less phytotoxic than normal serum. When, however, the same sera or spinal

fluids are tested on so-called *vernalized* or *yarovized* seedlings after subjecting to low but not death-dealing temperatures, or by exposure to suitable dosages of filtered x-rays, a very characteristic phytotoxic reaction is observed with syphilitic sera. This phytotoxicity is quantitative in nature, and runs parallel to the Wasserman or other serological tests. It is very useful in evaluating the anti-luetic efficacy of various antibiotics.

Another major research engaging the author's attention is a phytopharmacological examination of the blood in tumor patients. Several lines of approach have been tried and new ones are planned. Some very encouraging findings have been made. It can be provisionally stated that sera from cancer patients have so far been found to exhibit characteristic phytotoxic effects when studied on vernalized seedlings. Another peculiar property of cancerous blood sera in contrast to normal sera has been noted in connection with quantitative studies on the phenomena of photosynthesis taking place in certain aquatic plants. It is hoped that these novel approaches may contribute a bit to the sum total of our knowledge concerning this vital subject.

The author's methods for studying blood sera have been employed, especially in connection with studies on menstrual toxin, and psychotic blood sera by German, Russian, French and Italian investigators. In the U. S. these methods have engaged the especial attention of agricultural chemists. A detailed monograph by the author on Phytopharmacology with numerous references to literature is in preparation.

Thus with the development of this new department of biology some rather significant contributions have been made to our sum of knowledge. The above studies in phytopharmacology are a good illustration of the valuable results which may accrue through the collaboration of medical research men not only with the purely clinical laboratories, but also with the departments of the fundamental sciences, chemistry-physics, zoology, botany.

SYMPOSIUM ON THE DOCTOR IN COURT[1]

INTRODUCTION

WALTER D. WISE, M.D., *Moderator*[2]

The meeting seems to be in order without being called to order.

Judge Smith, Members of the Panel, and Members of the State and City Bar Associations, and of the State and City Medical Associations:

No matter how high the standards of procedure in any endeavor have been developed and maintained, there are no doubt opportunities for improvement. The problems that are to be considered in the symposium tonight encompass the range from the fundamentals—honesty, integrity and knowledge—to technicalities and techniques.

Many subjects will be discussed at this meeting. Some may be settled. Others will not be. It is hoped that much will result to aid lawyers and doctors, not only in Court, but in the State Industrial Accident Commission and also the Medical Board of the State Industrial Accident Commission.

It is well known that the scales in the hands of justice in this state are well balanced, but all equipment needs oiling and adjusting from time to time. And these are our functions tonight.

At the proper time, written questions from the floor

[1] Arranged by the Joint Committee on Medicolegal Problems of the Baltimore City Bar Association and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee.

[2] President of the Medical and Chirurgical Faculty of Maryland, 1951.

may be sent in, or you may arise and direct your question to the panel; and if there is sufficient time, we hope to be able to have some general discussion.

The speakers are asked to limit their papers to twenty minutes; and if we have time available for discussion, we will ask those who make remarks to limit themselves to three minutes.

The first paper this evening is to be on the subject of Medical Expert Testimony from the viewpoint of Trial Counsel, by Mr. Robert E. Coughlan, Jr.

Mr. Coughlan was graduated from St. John's College, with a Bachelor of Arts Degree, graduated from the University of Maryland, with a Bachelor of Law Degree, and for over twenty years he has been actively engaged in the trial of Workmen's Compensation cases and many cases in Court.

The best recommendation of Mr. Coughlan is that he was chosen by his peers to present this subject of Expert Testimony from the Viewpoint of Trial Counsel.

It gives me great pleasure to introduce Mr. Coughlan.

EXPERT TESTIMONY FROM THE VIEWPOINT OF TRIAL COUNSEL

ROBERT E. COUGHLAN, JR., ESQUIRE[3]

The subject which I have been asked to speak on, as far as the angle of the Bar is concerned, is going to be dealt with mainly from the standpoint of damage suits and Workmen's Compensation cases.

For the purpose of clarity, this topic has been divided into three phases:

1. From the standpoint of the Plaintiff.
2. From the standpoint of the Defendant.
3. From what could be considered the ideal standpoint.

The doctor's testimony in a suit for damages is the heart of the case. While it is true that there must first be liability before the Defendant can be required to respond in damages, the doctor is still the most important witness. When a doctor testifies on behalf of the Plaintiff, he should endeavor to testify not in accordance with his feelings, but in accordance with his findings. The Plaintiff's attorney, in seeking a doctor to examine his client so he may be apprised of the extent of the injuries, many times will try to obtain the services of not the best doctor from a medical standpoint, but the doctor who will make the best witness. The Plaintiff's attorney often times regards his duty to his client to obtain the largest verdict possible. He is not interested in what his case is worth, but how much he can get. He, therefore, seeks a doctor who will be possessed of knowledge, but whose conscience does not bother him. Such a doctor will testify not in accordance with his findings, but in accordance with what he believes he can get away with.

The two most serious types of injuries are back injuries, which the late Judge Roland Adams referred to, particularly in reference to sacro-iliac injuries, as "The Courthouse Joint," and head injuries. When a patient complains of pain in his back, many doctors will find no objective symptoms, but nevertheless will accept the word of the Plaintiff and base their findings of the disability accordingly. In fact, some doctors have gone so far as to state that when a patient moves his legs or his back and complains of pain, that the movement of the back or leg and the complaint of pain constitute an objective sign.

In head injuries, which are now rapidly becoming the most popular injuries, less conscientious doctors will testify that the patient is suffering from a post-concussional syndrome, that he should avoid heavy work, fatigue, climbing to high places, exposure to extreme heat or cold. When asked if, in his opinion, he thinks the complaint of pain is justified, the standard answer is "I believe so, and it is not unusual for these symptoms to persist as long as a year and

[3] Member of the Bar Association of Baltimore City and the Maryland State Bar Association.

many times they become permanent." The doctor will then continue and state that in view of the fact that the patient did not have any complaints of pain in his head prior to the injury and complains of pain since the injury, he must necessarily attribute the pain to the injury.

In recent years, the operation for ruptured intervertebral disc has opened a new field as far as doctors are concerned. If the x-rays show any narrowing of the intervertebral spaces or even in many instances, where they do not, the less conscientious doctor will interpret the x-rays, though not an expert in that field, as tending to show a narrowing of the spaces and will state the possibility of a ruptured disc.

In head injuries, electro-encephalograms are made and interpreted by the less conscientious doctor to indicate a disturbance of the brain. While not in a position to discuss the interpretation of either x-rays or electro-encephalograms, experience has shown, over a period of years, that in cases in which the doctor had testified that the patient had a possible rupture of an intervertebral disc, or a disturbance of the brain, that after the case was settled, the complaints disappear.

A real danger exists when medical testimony of this kind is given. Juries, like the public in general, sympathize with the underdog, the injured person, and reason, particularly if there is liability on the part of the Defendant, that the injured person did not have such complaints before the accident; that as he has ostensibly a reputable doctor testifying on his behalf, conclude that the person must have those complaints or injuries. They further reason that the doctor, who testified for the Defendant is employed by the Defendant for the purpose of discounting the claims of the Plaintiff and therefore, are not in many instances, impressed with such testimony, even though it is given by excellent medical men. Such testimony creates a hazard which Defendants and insurance companies should not be exposed to. Insurance companies and self-insurers expect accidents and expect to have to pay for them. For the most part, at the present time, they expect to pay reasonable amounts and are willing to do so. They do not expect to have to pay exorbitant verdicts where the injuries are not justified. The Bar attempts to police its members and keep them in line. Something should be done by the doctors to try to accomplish the same purpose.

Discussing this from the standpoint of the Defendant, the doctor for the Defendant should likewise be perfectly honest in his testimony. He should not underestimate the claim and he should not underestimate the percentage of disability. Unfortunately, in some instances, this is done. The reason for it, which is not a good one or a sound one, is that doctors who have had a great deal of experience in damage suit cases, knowing that the Plaintiff's doctor will exaggerate, have a tendency to minimize the claims and underestimate the percentage of disability. This kind of testimony is almost as bad as that of the unscrupulous doctor for the Plaintiff.

A law suit should not be a battle of wits. It should be an honest determination on the part of the litigants on both sides to present their case fairly and honestly in order that a Jury may determine the issue. There are many cases in which perfectly honest lay witnesses will view the accident and testify almost in direct opposition to each other. This can be explained and accounted for in many instances on account of the fact that no two people will see the accident from precisely the same angle. It is perfectly possible and reasonable to expect honest differences of opinion as far as the medical profession is concerned. When, however, one doctor will testify that the man has a 50% loss of use of his back and a doctor for the opposing side will say that he does not have any disability or perhaps a 5% disability, then something is wrong. One of the doctors is badly mistaken or deliberately not telling the truth.

When the new rules of Practice and Procedure were adopted, the element of surprise, to a considerable degree, was taken out of a case. The

names of witnesses can be obtained and their testimony taken so that each side will know, to a degree at least, what their testimony will be. This goes a long way toward solving the question of liability. When, however, the testimony of the various doctors is taken, many times their opinions are so completely at variance, that it is utterly impossible to reconcile the difference. If the doctors are honest in their divergent views, then the lawyers, if honest, for the respective parties could accomplish a great deal if they approach the problem by getting one or two totally disinterested doctors to examine the Plaintiff and give a report. This would be a long step toward correcting the abuses that exist at the present time.

Most any member of the Bar who has been actively engaged in the trial of damage suits can cite, from his own experience, numerous instances of false and incorrect medical testimony. To refer to one such case, while appearing for the Plaintiff, the question was whether the Plaintiff, who had developed epilepsy as a result of the accident, was permanently totally disabled. The case was investigated from a medical standpoint and it was learned that the initial injury was a fractured skull with displacement of the fragments. The immediate problem for the attending physician, who first saw and treated the Plaintiff, was whether to operate and take a chance on adhesions or not to operate and take a chance on what might happen. The doctor decided not to operate. When epilepsy developed, the insurance company produced this doctor who testified that an operation would relieve the present condition and the man would be all right. Doctors who had examined the Plaintiff on his own behalf were of the opinion that an operation was dangerous and that things had better remain as they were. The doctor who saw the man originally and treated him as a result of the accident testified that an operation would cure him, even though some two years had elapsed since the initial injury. Furthermore, after explaining what was necessarily involved, when pressed on cross-examination as to the dangers involved in such an operation, he testified that it was as simple as a tonsilectomy. This testimony was obviously not honest, but an attempt to cover up.

It is urged that the doctors themselves do something about those members of their profession who give basically false and untrue testimony. It is further urged that steps be taken, if not to discipline, to educate the doctors so that they will not give misleading testimony. The difficulty lies with the doctors. The men of high standing are tremendously busy and take the position that it is their duty to treat the sick and not become professional witnesses. They are horrified when classic examples of distorted testimony are brought to their attention, but they become squeamish about taking any steps to correct it. They do not wish to become involved in such unpleasant matters. It is a breach of professional etiquette to testify against another doctor or in any way take him to task. Thus the unscrupulous doctor continues to give false testimony, Juries are misled, Defendants pay much more than they should and the evil continues.

Steps can be taken by the doctors that would be corrective and salutary. Doctors, when asked to appear in Court, complain about the loss of time in waiting before they testify. To a very great extent, this has been eliminated and can be improved even further if counsel are competent and the Judges cooperate. Sometimes, however, a doctor is asked to be present to hear the opposing doctor testify and in order to keep him in line by his very presence in the court. This should not be necessary and if the unscrupulous doctor knew that his testimony would be reviewed by a board of competent doctors and that he would be disciplined or educated, as the case may be, the evil to a great extent could be corrected.

If the doctors could agree on a method to evaluate disability and if the doctors would cooperate with the Bar, and the top flight men in their profession would give a portion of their

time to examine and testify in cases in which there is an honest divergence of opinion, great headway would be made toward correcting the present conditions.

A doctor should not be an advocate for the side that he represents, so to speak, nor should he be fearful because of unfair cross-examination. The Judges in the respective courts, for the most part, will see that the doctor is not harshly treated.

Some doctors, who are familiar, to a certain degree, with the rules of evidence, will blurt out a statement which they know from their experience in testifying is not admissible, but do so for the sole purpose of assisting their side of the case. A conscientious doctor will not adopt such tactics nor will he be a party to any scheme concocted by the attorney to bring out evidence that is not admissible. While it is true technically such evidence is striken from the record by the Judge, the Jury has heard it and many times is influenced by such statements, arguing among themselves that while such statements are legally inadmissible, they are, none-the-less, true and should therefore be given consideration.

A word should be said with regard to claims under the jurisdiction of the Workmen's Compensation Act. Fortunately, a considerable number of highly competent doctors are specializing in this field. The members of the State Industrial Accident Commission usually, in the course of time, become acquainted with the doctors who appear before them and are able to determine the ones that they can rely on. In a case where a doctor for the Claimant estimates the disability to a man's back at 75% and the employer and insurer's doctor estimates the disability at 5%, the Commissioner ordinarily will ask the attorney for the employer and insurer if he will agree to the Commissioner sending the man to another doctor and if he will pay the bill. In the vast majority of cases, the attorney for the employer and insurer will readily agree to this and if a competent man is selected by the Commissioner, a fair award will ordinarily be passed. Therefore, in the cases before the State Industrial Accident Commission, there is a greater chance for a fair award but unfortunately, however, what usually happens is that, if the Claimant does not get what his attorney thinks he *can* get him, the Claimant's attorney takes an appeal. When the case is tried before a Jury, the Defendant's attorney is faced with the same situation as he is faced with in a damage suit. For this reason, strenuous efforts should be made by the doctors to keep the medical testimony before the State Industrial Accident Commission within bounds, and the doctors appearing before the Commission should be made to realize that their testimony will be just as carefully scrutinized as if it were given in the law courts.

Cooperation between the doctors and joint examinations under the supervision of a third nonpartisan doctor would be a tremendous step forward in the direction of stamping out the practice which now exists. Not so long ago, one of the most reputable orthopaedic surgeons examined an injured man and reached the conclusion that he had a large percentage of permanent disability. The insurer's doctor was very much of the opposite opinion. Another doctor was selected by the insurer and an examination was made of the man and this third doctor agreed wholeheartedly with the doctor for the insurer. This third doctor, so to speak, unknown to the attorneys in the case, arranged for an examination between the orthopaedic surgeon who had seen the man at the request of his lawyer, the insurer's doctor and himself. This doctor was able to convince and to demonstrate to the Claimant's doctor, so called, that he had been misled and fooled by the Claimant so that he completely revised his previous opinion and the result was a settlement of the case for a very small percentage of the disability. This illustrates what can be done if the doctors cooperate.

In giving testimony, the doctor should be careful to discuss the injuries in such a way that a Jury can understand him and not stick to technical terms. Many times a Jury becomes

utterly lost in the terms used and when they discuss the case in the Jury Room, they are hopelessly confused.

A rather classical illustration was a little case in which the lawyer for one side said, "Doctor, in language as nearly popular as the subject will permit, will you please tell the Jury what the cause of this man's death was?" And the Doctor said, "Do you mean the proximate causus mortis?" The lawyer said, "I don't know, I will have to leave that to you." And the doctor said, "Well, in plain language, he died of an oedema of the brain that followed a cerebral thrombosis or possibly embolism that followed, in turn, an arteriosclerosis combined with the effect of a gangrenous cholecystitis." And a Juror said, "Well, I'll be damned." The Court said, "Ordinarily, I would fine a Juror for saying anything like that in court, but I cannot in this instance impose a penalty upon you, sir, because the Court was thinking exactly the same thing."

As far as the Bar is concerned, the Bar can help themselves a lot with their questions, as may be shown by this illustration: A lawyer said to the witness, "Now, sir, did you or did you not, on the day in question, or at any time previously or subsequently, say or even intimate to the defendant or anyone else, whether friend or mere acquaintance, or in fact a stranger, that the statement imputed to you, whether just or unjust, and denied by the plaintiff, was a matter of no moment or otherwise? Answer, did you or did you not?"

"Did I or did I not what?" asked the witness weakly.

DR. WISE: Well, that was quite a castigation of the medical profession, I think.

And I hope sometime we will have on this program the doctor's idea of the way lawyers conduct their cases in court.

The next paper is by Dr. Conrad Wolff, Expert Testimony from the Viewpoint of Industrial Medicine.

Dr. Wolff is a graduate of McGill University of Montreal in 1917, and a Veteran of World War I. He came to Maryland in 1927, and has made quite a place for himself here in that time.

He has been affiliated with the Johns Hopkins Hospital, the Union Memorial Hospital and Mercy Hospital.

He is a member of the Medical Board of the State Industrial Accident Commission, and he is Associate Professor of Medicine at the University of Maryland Medical School.

The Courts have had centuries of time to develop their procedures. This Commission has had but a few years. It is well known that they have done excellent work and deserve a great deal of credit and thanks from the public, from the medical profession, and all citizens.

It gives me great pleasure to introduce Dr. Wolff.

EXPERT TESTIMONY FROM THE VIEWPOINT OF INDUSTRIAL MEDICINE

THOMAS CONRAD WOLFF, M.D.[4]

The Medical Board of the State Industrial Accident Commission was started some years ago as an advisory board to the State Industrial Accident Commission in matters of disease as distinct from traumatic injury.

Consequently the Medical Board deals in occupational diseases such as silicosis, silico tuberculosis, dermatitis, a large variety of diseases resulting from contact with industrial fumes, and an infinite variety of other conditions that come largely under the head of internal medicine.

"Expert Evidence" by competent authority in Industrial Medicine, a division of Internal Medicine, should be utilized wherever there exists litigation about Industrial disease as distinct from Industrial injury.

Litigation commonly takes place in the form of hearings before Judge and Jury or before duly

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appointed Commissions or Boards of Inquiry. Lawyers representing respective sides of a dispute hire their expert evidence and these experts are expected to speak for their side.

Such is the current system. Nobody regards it as ideal but there is no widespread movement to correct it.

For clarity, it will be necessary to define certain terms. Do any of you know a definition of "Expert Evidence" as it applies to medicine? The average lawyer will probably tell you that it means "Evidence on a medical subject by a Doctor of Medicine." Such a definition, so all-inclusive, becomes an absurdity when one realizes the infinite complexity of Modern Medicine. No single Doctor of Medicine could become familiar with all branches of medicine to a degree where his testimony could be rated as universally expert. Yet it is not uncommon practice for lawyers to seek as "Expert Evidence" physicians who have insufficient familiarity with the subjects at issue. The reasoning appears to be, "He is a Doctor of Medicine. He knows something about the subject. We can use him."

I have no wish to reopen old cases nor to indulge in personalities. I shall, therefore, submit to you two cases as examples. However, I shall make a few fictitious changes in some of the details, preserving enough of the essentials so that the cases may serve as valid examples.

A widow appears in court to claim damages because her husband may have died from an occupational lung disease. Her Attorney has brought to the hearing a "Doctor of Medicine as Expert Testimony." This doctor seems to have had something of a migratory career. Currently, he is doing a general practice. At one time he was an interne on the staff of a rather obscure institution for the treatment of diseases of the chest—but that was many years ago. The hearing is held before a Medical Board for Occupational Disease composed of doctors who owe their appointments to approval by their State Medical Society, and not to any political considerations.

These doctors cross question the "Expert Witness" and learn almost at once that his knowledge is fundamentally lacking. He reasons falsely from ignorance of basic science. His conclusions are untenable. However, he is glib and has picked up enough pseudo-professional jargon so that in the hands of a sharp lawyer he could probably impress a jury. However, he is heard by physicians, not by jurymen, and the value of his testimony is zero.

Why has the attorney brought such a man to the witness stand as his Expert Evidence? Why has such a doctor connived at being rated as Expert Evidence in a matter in which his knowledge was so palpably deficient?

Before citing my second case, I must remind you that in the profession of medicine, highly qualified men from internationally famous institutions of research constantly reexamine our stocks of professional information—text books and such. The results of their labors often oblige us to revise opinions held in respect for years. Many text books contain items of information which current research has rendered untenable. Bear this in mind as I cite my second case.

A skilled laborer who had spent his working life in contact with various metals died during one of the terminal events of arteriosclerotic cardiovascular disease. His widow remarked to her attorney that her husband's life had been healthy until recently except for an attack of lead poisoning many years previously. The attorney then told her in effect that lead poisoning causes arteriosclerosis. He reminded her that her husband had worked for the same firm for 40 years; that he had developed lead poisoning while in the employ of this firm; that the firm was, therefore, liable for her husband's death on the grounds of occupational disease.

A hearing is held before the Occupational Disease Board. The members of this board are aware that according to the recent findings of a research organization of high international repute, any connection between the disease of arteriosclerosis and lead poisoning is purely coin-

cidental. The decision of the board absolves the insurer from responsibility in the death of the man.

A member of the State Accident Commission, a lawyer, reverses the decision of the Medical Board.

The board announces its reversal to the director of the above mentioned research organization who in turn agrees to attend a re-hearing of the case as the Board's Expert Testimony. He spends considerable time in outlining the processes whereby the research organization had arrived at its conclusions in respect to the coincidental character of lead poisoning and arteriosclerosis. He submits to cross questioning by opposing counsel.

As rebuttal the attorney for the widow introduces his Expert Testimony. This is a doctor of medicine who admits that his specialty is far removed from the subject of industrial poisons and their effects. He denies that he has ever treated any cases of industrial poisoning. It seems that he has had no particular interest in the subject until employed by the attorney as Expert Evidence. He states that the texts he has read on the subject favor the hypothesis that lead poisoning produces arteriosclerosis.

The case ultimately proceeds to a higher authority, where the outdated opinion of the text books is upheld and so now, for all time, scientific research of the highest type to the contrary notwithstanding, the law asserts that lead poisoning produces arteriosclerosis—and all is embalmed and hallowed in legal precedent. It does not require an abnormal imagination to visualize the gainful opportunities for old men who at one time suffered from lead poisoning, not to mention the financial emoluments accruing to the type of lawyer and doctor who would prod them into litigation.

Do the gentlemen of the legal and medical profession in the State of Maryland approve such techniques of their brother professionals? If they disapprove, is there any present machinery whereby they may visit their disapproval upon those who incur it? If there is no present machinery, can some be devised?

Inasmuch as I know of no generally accepted definition of Expert Medical Witness, I am emboldened to hazard one of my own.

An Expert Medical Witness may be defined as a "doctor of medicine who restricts his testimony to subject matter wherein he has become familiar through years of interest as manifested by study, research or practice; that his competence in such subject matter is known to his colleagues; and that his reputation for integrity has not been called into question."

I should like to see the governing body of our medical society issue at specified time intervals a panel of such Expert Medical Witnesses, properly classified as to their fields of knowledge. These witnesses' periods of availability should be short and some provision should be made to defend them against repeated demands on their time. However, these witnesses should meet reasonable demands as a matter of civic responsibility.

Such a panel of Expert Medical Witnesses should be available to the law society.

And now with great hesitancy, I should like to ask few important questions.

1. Is it possible in a difficult and complicated medical litigation, that the presiding officer of the Court, Commission or Board of Inquiry have the power to draw from the panel issued by the medical society the names of whatever Expert Witnesses may seem to him to be necessary? Or alternatively could the medical society make these nominations at his request?

2. Would it be possible that these Expert Witnesses be furnished with case histories, laboratory reports and stenographic transcripts of the legal procedures that have already taken place?

3. Would it be possible to accord these Expert Witnesses reasonably adequate time in which to review the medical evidence and reach reasonable conclusions?

4. Would it be possible to arrange for the pro-

tection of these witnesses against the importunities of Counsel, or other interested persons while reviewing the evidence, though subject to cross questioning in court after they had reached their conclusions?

5. Would it be possible to arrange that the emoluments of these Expert Witnesses be added to the costs of court and defrayed ultimately according to the direction of the presiding officer of the Court?

6. Would not such a system as this do away with the undesirable situation where each side to the dispute has its own "Expert Witness"?

I should like very much to see these matters discussed, because, as I view it, constructive changes in some present techniques may very well be indicated.

SUMMARY

A. A suggestion is made that a definition of EXPERT MEDICAL WITNESS be reached by consultation and agreement between our legal and medical societies.

B. Testimony of such EXPERT MEDICAL WITNESSES as so defined will be the only type admitted as EXPERT EVIDENCE before courts, commissions and boards of special inquiry. Infraction or attempted infraction of this stipulation by lawyers or doctors should incur the displeasure and appropriate disciplinary action of the law and medical societies.

C. That a properly classified panel of such EXPERT MEDICAL WITNESSES be nominated by the medical society for short periods of service, to be replaced by another such panel when the period of service has expired, and that the doctors on such panels reply to calls for such service as a matter of civic obligation.

D. That such EXPERT MEDICAL WITNESSES be selected as seems necessary by the presiding officers of courts, commissions and boards of inquiry, and that these WITNESSES serve as representatives of courts, etc.

E. That the present practice wherein each side to a litigation hires and pays its so-called EXPERT MEDICAL WITNESS be discontinued.

F. That emoluments accruing to EXPERT MEDICAL WITNESSES be added to the "Costs of the Court" and defrayed through Court Order, the EXPERT MEDICAL WITNESS has therefore no conceivable personal or prejudiced interest in the outcome of the dispute.

DR. WISE: We have five speakers, and have only heard two of them. I think if the meeting were called off now, it would have been well worth while. I can foresee that good is going to come out of this meeting.

The next speaker is also a Canadian who has endeared himself to Baltimore.

His subject is Expert Testimony from the Viewpoint of Traumatic Surgery. The speaker is Dr. George Eaton, who was born in Nova Scotia. He is a graduate of McGill University, like Dr. Wolff. He is Assistant Professor of Orthopedics at Johns Hopkins University School of Medicine; Assistant Medical Director at Children's Hospital School, and Visiting Orthopedic Surgeon at Union Memorial Hospital, Church Home and Hospital, Women's Hospital of Maryland and Bon Secours Hospital.

He is a member of the American Academy of Orthopedic Surgeons, American Orthopedic Association, and several other professional and other organizations.

I would like to digress for a moment to just recount a little personal experience, if I may be allowed that privilege.

Dr. Eaton served in World War II, rapidly became recognized in the Pacific, and was made a Consulting Orthopedic Surgeon, which was a high ranking position. He came back to Baltimore, and unfortunately got here just about the time of the Battle of the Bulge. We had to reactivate East Coast Hospitals that had been practically closed. Patients were being flown in here at a terrific rate. One hospital, which was very unattractively located, had 1500 orthopaedic cases, consisting in a large percentage of compound fractures of the femur and the humerus. They had one well trained orthopaedic surgeon, and several less well trained. The chief orthopaedist could not make the rounds of 1500 patients in a week. He could not see all of his patients and do his other work. Dr. Eaton was asked if he would step down from his high position of Consulting Surgeon and take a plain orthopaedic surgeon's job in that hospital and divide the service with the other orthopaedist. He graciously did it. That is the kind of person he is.

It gives me great pleasure to introduce Dr. Eaton.

EXPERT TESTIMONY FROM THE VIEWPOINT OF TRAUMATIC SURGERY

GEORGE O. EATON, M.D.[5]

My remarks are perhaps not going to be too condemnatory, but perhaps they will stir a little bit of comment or questions.

In the interests of justice, anyone can be compelled to attend court to testify to facts within his knowledge. A doctor may be issued a subpoena to testify as to facts, and he may be adjudged in contempt of court should he refuse to obey the summons. Such a witness is classified as a statutory witness in contrast to the expert witness.

Expert testimony consists of delivering opinions which are based on a specialist's knowledge and experience and which the court needs in order to understand properly the merits of the case. Workmen's Compensation laws and the constantly enlarging field of insurance are especially productive of the need of expert medical testimony, particularly concerning traumatic cases. We are morally obligated to attend court and testify for the patient whom we have treated for injuries on which the court action is based. Our services can also be solicited by the plaintiffs or their counsel for the purpose of examining a patient, rendering a written opinion, and being prepared to testify during the trial.

A very large proportion of the members of the medical profession avoid, if possible, giving expert testimony, one reason being that it entails a cross-examination which sometimes seems to question the honesty of the witness and subjects him to the insinuation and sarcasm of the opposing counsel. The doctor should keep in mind that he has the superior knowledge and that his is the role of an instructor in the court.

The sole aim of the medical witness should be directed toward maintaining a clear issue and to expedite in every practical way the ends of justice. That function should rule out all bias and tendency to partisanship. The task of freeing medical testimony from all improper factors and influences is ours. If, on the witness stand, a doctor violates the standards of his profession, some other doctor is sure to know of it. On the latter rests the initial responsibility, for activating the professional attention deserved by the misconduct.

In court and on the witness stand, you will have the feeling that the lawyer on your side is your friend and that the lawyer on the opposing side is not. Actually, this idea is not justified. Most opposing lawyers are equally interested in a good performance on your part and will tend to admire a modest and courteous attitude.

In answering questions, tend to address the jury and the judge rather than only the interrogating lawyer. Keep your voice up and speak clearly, that you may be understood and that the court stenographer may record what you say. It is considered most important to tell the truth, the whole truth and nothing but the truth. It is a mistake to volunteer information thinking that it will help the case alone. Do not attempt to help the counsel on either side. Answer as briefly as is reasonable the questions which are propounded. Try to be attentive to all questions. Try not to give the impression that you know it all. Above all, be very frank. If the lawyer propounds a question, the answer to which you do not know, do not hesitate to state that you do not know the answer. The court recognizes that no witness is completely informed on all subjects, and such a response to a question is not considered detrimental. If the opposing counsel appears to be deliberately irritating, it is most important not to lose your temper and to take your time so that you will not contradict previous testimony.

The question of remuneration for expert testimony might be briefly discussed. Famous opin-

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ions have been handed down that a doctor's special knowledge is his property and that a court may not take his property from him without remuneration. In the case of a statutory witness, a nominal witness fee is paid to compensate him for his loss of time from work. In the case of the expert witness, the doctor should charge for his time in court. A useful procedure is to inform the lawyer in writing, before you examine a patient that you demand that the lawyer assume responsibility for payment of charges for examination, x-rays if taken, and rendering a written opinion. In addition, if the case comes to court, you should, before trial, obtain a guarantee from the lawyer that your fee for testifying in court will be paid. As a matter of fact, doctors have been subpoenaed, and have been compelled to attend court, to give expert testimony without remuneration being arranged. This is the exception rather than the rule, and as a procedure will not bear close legal scrutiny.

It is important to remember during the examination of the patient for the purpose of legal procedures not to prescribe for the patient, or even give opinions to the patient as to his diagnosis, treatment, or prognosis. This is the province of the doctor who is treating the patient.

The expert witness should take to court with him the report of his examination of the claimant. He should expect to read that report to the court and interpret medical terms as he goes along. It is most important to remember that neither the judge nor the jury understand what a trochanter is or what a diastasis is. If you use such terms in court, it will be resented by the court since it exposes their medical ignorance. As you talk, think ahead and substitute lay terms insofar as possible for medical terms.

Appraisal of injuries and their immediate and future disability-potentialities is a complicated and important subject. It requires extensive knowledge of all diagnostic procedures necessary to evaluate the exact nature of the injuries and the probable consequences of natural healing and degenerative changes over the remaining life of the patient. The expert must approach the case study with a completely open mind, determined to assemble all facts necessary for the establishment of correct diagnoses and complete comprehension of all matters relevant to the situation. Too often prejudicial factors resulting from biased attitudes, limited experience, preliminary prejudicial conferences with lawyers or adjusters, and hostile or ingratiating patient attitude consciously or unconsciously channel the conclusions which he reaches. This is particularly true where the objective findings are in contrast with the subjective complaints. Frequently this accounts for the wide disagreement between otherwise honest and sincere experts.

The history which the patient gives and his demonstrations of function must be subjected to close scrutiny. Inconsistencies and unusual findings must be noted and appraised carefully and an effort must be made to find their cause and classify them.

The most common form of inaccuracy on the part of the patient is exaggeration. This seems to become progressively greater as the case advances and the history is repeated to successive examining physicians. Misstatements entirely unsupported by fact are frequently made in order to establish an unfounded allegation. Headaches, dizziness, etc., are not uncommonly ascribed to cerebral concussions which never occurred. Momentary unconsciousness immediately after an automobile or other violent accident is referred to as a possible concussional reaction when as a matter of fact, the patient only fainted and had no physical trauma direct or indirect to the skull or its contents.

Many "back cases" of long standing and frequent recurrences offer themselves as fresh and primary injuries, and the physicians then wonder why they cannot be cured in the customary and usual length of time. The pitfalls in this field are legion. The physical examination must be sufficiently inclusive, not only to elicit and record all specific effects of the injury itself, but should

include an appraisal of the general physical condition of the patient. Accurate observations of the form and function are important and wherever possible, exact measurements should be made. In a low back examination, the question of the presence or absence of muscle spasm has often come into issue. True spasm beyond control of the patient is a significant finding. However, all too frequently, voluntary muscle contraction in response to the patient's will, or, reaction to faulty body mechanics and posture is causing spasm, and thus is given undue importance. Measurement of symmetrical parts of the body can be made a valuable feature of the physical examination. In the case of long standing disability in a knee, some degree of atrophy of the thigh muscles on the involved side would be a reasonable expectation. If such evidence were lacking, there should be a substantial basis of doubt, particularly where no other supporting evidence of disability could be identified. By the same token, callouses on the hands, uneven wear of shoes, localized atrophy, correlation of active and passive limitation of joint motion, x-ray changes which obviously antedate the duration of complaints are important data in estimating the climant's status. Painful joints, if superficial, usually exhibit some degree of increased heat or redness or swelling.

Nature often achieves wonderful cures after the physician has exhausted his resources and the claim has been adjusted or adjudicated. On the contrary, many situations such as joint and disc injuries deteriorate progressively, often leading to serious disability which was not considered or anticipated at the time of initial management of the case. It is the expert's duty and responsibility to understand, explain and weigh these potentials.

While injuries of the extremities readily lend themselves to classification and grading, those of the spinal column and head cannot be catalogued so easily. These latter injuries therefore fall into the group which are known as "non-schedule injuries." Permanent disability appraisal in these cases is based upon "the proportionate extent of the impairment of the injured's earning capacity in the employment in which he was working at the time of the injury, and other suitable employments."

At the conclusion of a competent examination, the expert should be able to set up a mosaic of evidence which either proves quite clearly that a real injury has occurred or show that the complete absence of such evidence or its utter inconsistency presumes that no significant abnormality is present. Even, given exactly the same facts, conscientious experts can and will disagree with regard to their significance and potentialities. Mere disagreement between experts does not imply dishonesty or incompetence on the part of one or both of them.

(*Continued in May Journal*)

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THE HOSPITAL STANDARDIZATION PROGRAM

The Appointments to the Joint Commission on Accreditation of Hospitals and the various organizations which they represent, have been announced:

American College of Physicians:

Alexander M. Burgess, M.D., Providence, Rhode Island

William S. Middleton, M.D., Madison, Wisconsin

LeRoy H. Sloan, M.D., Chicago, Illinois

American Hospital Association:

Edwin L. Crosby, M.D., Baltimore, Maryland

Judge Milton George, Morden, Manitoba

John H. Hatfield, Philadelphia, Pennsylvania

Right Reverend Monsignor J. J. Healy, Little Rock, Arkansas

A. J. J. Rourke, M.D., San Francisco, California

Charles F. Wilinsky, M.D., Boston, Massachusetts

American College of Surgeons:

Arthur W. Allen, M.D., Boston, Massachusetts

Evarts A. Graham, M.D., St. Louis, Missouri

Newell W. Philpott, M.D., Montreal, Quebec

American Medical Association:

Gunnar Gunderson, M.D., LaCrosse, Wisconsin

L. W. Larson, M.D., Bismarck, North Dakota

Julian P. Price, M.D., Florence, South Carolina

Stanley A. Truman, M.D., Oakland, California

Herman G. Weiskotten, M.D., Skaneateles, New York

Rolland J. Whitacre, M.D., East Cleveland, Ohio

Canadian Medical Association:

E. K. Lyon, M.D., Leamington, Ontario

(A. D. Kelly, M.D., Toronto, Ontario, Alternate)

The Joint Commission held its first meeting on Saturday and Sunday, December 15 and 16, at the Drake Hotel in Chicago. Further details concerning the plan for the Joint Commission on Accreditation of Hospitals have been published in the Bulletin of the American College of Surgeons, 40 East Erie Street, Chicago 11.

Insurance

PRESIDENT'S REPORT TO THE BOARD OF TRUSTEES*

HUGH J. JEWETT, M.D.

The year 1951 was the first full year of operation for the Blue Shield Plan in Maryland. I believe we should look at it as an experimental period, one of trial and error, during the course of which we have been able to judge the effectiveness of the program and its acceptance by the Maryland community. We have made a good start in 1951 and have accomplished much, but it is clear that there is room for improvement and much more to be accomplished in the years ahead. We have only scratched the surface of our potential market.

First, let me relate briefly the highlights of our operations in the past year. As of December 31, 1951, we had enrolled a total of 57,472 persons under the standard Blue Shield program, or approximately 7½% of the number of persons covered under Blue Cross. These subscribers were enrolled through some 1400 different employed groups and through a one-time offering to the Blue Cross subscribers paying on a direct basis. In retrospect, we had hoped for a higher enrollment figure at the end of the first year—some had predicted 75 to 100,000—but the results were nevertheless reasonably encouraging.

In addition, through a special national agreement with the Bethlehem Steel Company and its union, there has been in effect since September 1, 1951 a separate surgical indemnity program covering some 102,000 steel company employees and their dependents in Maryland. Actually, therefore, under the two programs we now have 160,000 persons eligible for Blue Shield benefits.

Our financial experience in 1951 under the standard program was favorable. Payments to physicians for benefits rendered took about 70¢ of the subscription dollar. However, because of the 12-month waiting period for obstetrical care and for tonsillectomies, very few such cases were covered in the past year, and we can therefore anticipate a higher payment ratio in the year ahead. Administrative expenses paid to Maryland Hospital Service (Blue Cross) took 11.7% of subscription income, a relatively low percentage considering the heavy introductory expenses during the first year of Blue Shield operations.

Benefits were paid during the year to 4,710 subscribers, or about one out of every twelve enrolled. The Plan payments covered about 74% of the total cost of care as represented by charges made by physicians, and constituted full payment in 60% of the cases. Thus, while additional payments were required from about 40% of the subscribers receiving care because their incomes exceeded the established limits for service benefits, these payments totalled only one-quarter of the overall cost of care to subscribers.

So much for the 1951 results. Now I would like to review briefly the various factors which have prompted us to undertake certain revisions in the Plan, both as regards scheduled benefits and subscription rates. These revisions, as you know, were approved by the Board in January of this year, and are now awaiting approval of the State Insurance Department.

From the beginning, some difficulty has been experienced in selling the Blue Shield Plan on a voluntary basis. Presenting it to large groups with a majority of employees already enrolled in Blue Cross, it was found that an insufficient number of employees signed up for the new program to meet the required quota for formation of a group. Consequently, we have been able to enroll the employees of relatively few large companies on a voluntary basis. This is, of course, not true in those groups where the employer pays a part or all of the subscription charges.

The less-than-anticipated enrollment total during

* Annual Meeting of Maryland Medical Service, February 27, 1952.

the first year of operation can be attributed to several factors of varying importance. To some extent it has been due to the newness of the whole program and the slowness of the general public to fully understand and appreciate it. In part, it can be attributed to the fact that Blue Shield was late in starting in Maryland, and many companies already have a surgical coverage for their employees through a commercial insurance carrier.

Of major importance, however, have been three basic factors in the structure of the Plan itself, namely, (1) the high family rate in relation to the individual and husband and wife charge, and in relation to the Blue Cross rates; (2) the low income limits under which service benefits are provided; and (3) the peculiarites in the fee schedule arising from the category divisions.

There is not time here to discuss in detail these various points. Suffice it to say that the combination of them has had a retarding effect upon the enrollment picture. Two steps already have been taken to remedy this situation, namely, the proposed adjustments and revisions in the fee scuedule and in the subscription rates. A third step, an increase in the income limits for service benefits on the family coverage, will be presented to the Medical and Chirurgical Faculty at its April meeting. With these three changes, there is every reason to believe we will have a much more acceptable program.

I cannot close these remarks without extending my thanks and appreciation to the 1,560 physicians in the State who now are participating in Blue Shield and who have cooperated so splendidly during the first year of operations. It is encouraging to note that 150 of these physicians have signed participating agreements since the Plan started a year ago last November, and more are signing up every week.

With the adjustments that are being made in the Plan itself, and with the continued cooperation of the physicians throughout the State, I am confident that Blue Shield will be able to extend its coverage widely in the year ahead, thus taking its place beside Blue Cross as the community's accepted program for the provision of surgical and medical care on a prepayment basis.

ANNUAL GOVERNORS SAFETY AND HEALTH CONFERENCE

Baltimore, Maryland

May 8 and 9, 1952

The Industrial Nurses Section of the Annual Governors Safety and Health Conference will hold its meeting on Thursday, May 8, 1952, at 8 p.m. at the Lord Baltimore Hotel.

The theme of the meeting will be, "AFTER 60, WHAT?" The following will be the program: "Health and Psychological Aspects of Retirement" by Dr. Milton Landowne, Associate Chief Gerentology, National Institute of Health, Baltimore City Hospitals, and "Planning with the Employee for Retirement" by Rear Admiral Frederick Bell, U.S.N. Retired, Director of Human Relations, McCormick & Company, Inc., Baltimore.

The Program Chairman, Margaret E. Kramer, extends a cordial invitation to the physicians of Maryland to attend this meeting.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

OUR THIRD ANNUAL MEETING, at The Stafford Hotel, on Wednesday, April 30th from 10:00 A.M. through 3:00 P.M. will include a one hour luncheon, starting promptly at one o'clock. The doctors are also invited to attend and hear our speaker, Dr. Louis Krause. Plan to be present at this luncheon with your husband! In addition to the luncheon, our Annual Meeting Program will feature movies and exhibits for Auxiliary "Health Booths" at County Fairs, Round-Table Discussions, and a Fashion Show, not to mention our business meeting. Every member of the Auxiliary and all Faculty wives are urged to come. Write to the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland, for information if you do not receive a notice in the mail. Plan to come to your ANNUAL MEETING!

Arrangements for THE ANNUAL MEETING have been made by Mrs. Thomas A. Christensen, *Chairman of Arrangements*, and her Committee, Mrs. George G. Finney, *Decorations;* Mrs. M. Elliott Randolph, *Fashion Show;* Mrs. L. C. Dobihal, *Hospitality;* Mrs. R. Walter Graham, Jr., *Tickets;* Mrs. Albert E. Goldstein, *Publicity;* Mrs. Emil G. Bauersfeld, *Finance.*

The CREATIVE ARTS SHOW, on view April 28–30 at the Faculty Building, an exhibition of art work by our doctors and their families, was arranged by Mrs. Beverley C. Compton, *Chairman*, and her Committee: Mrs. Frank R. Smith, Mrs. Marius P. Johnson, Mrs. John W. Parsons, Mrs. Benjamin H. Rutledge, Mrs. Howard C. Smith, Mrs. I. Ridgeway Trimble, Mrs. Lawson Wilkins and Mrs. Walter L. Winkenwerder.

NEWS FROM COMPONENT AUXILIARIES

The Woman's Auxiliary to the Baltimore City Medical Society most graciously invited the entire membership of the Woman's Auxiliary to the Medical and Chirurgical Faculty to a State-wide meeting on Wednesday, April 2nd at 11:00 A.M. at the Faculty Building, to meet Mrs. Harold F. Wahlquist, our National President, Woman's Auxiliary to the American Medical Association. A buffet luncheon followed. It was a privilege to meet this wonderful woman who represents us nationally. We are proud to claim Mrs. Wahlquist as our President! Our gratitude to the City Auxiliary for its hospitality!

The Woman's Auxiliary To The Baltimore City Medical Society also sent a delegation of its members to the City Hall, in Baltimore, on March 8th to a hearing on the fluoridation of water which was being opposed by certain organizations. Mrs. H. Hanford Hopkins and Mrs. George H. Yeager, Presidents respectively of the City and State Auxiliaries, also wrote letters favoring fluoridation and supporting the position taken by the Medical Societies.

The Baltimore County Auxiliary celebrated "Doctor's Day" on March 29th by having a dance at the Randallstown Community Hall, to raise funds for their second Nursing Scholarship. This represents a splendid effort and accomplishes the dual purpose of honoring the doctors and raising funds for a worthy purpose. Congratulations on a fine job!

Mrs. A. Austin Pearre, President of the Woman's Auxiliary to the Frederick County Medical Society reports that their recent, all-local Fashion Show was a tremendous success. Mrs. George H. Yeager, State President, and Mrs. Amos R. Koontz, Vice-President, who attended from Baltimore, were impressed by the enthusiastic reception. Tickets sold out early. Funds raised will go to their Doctors' Library.

The Auxiliary to the Washington County Medical Society surprised their Medical Society with a "Doctor's Day" luncheon. We understand that the party was enjoyed all the more for having been kept secret.

Prince George's also celebrated "Doctor's Day" with a luncheon for all their physicians, which was held on March 31st at the Prince George's General Hospital, and was served by Auxiliary members. The old custom of pinning a red carnation on each doctor in honor of the occasion was observed. This affair won favorable comment from every doctor.

A SMALL TOKEN

The Woman's Auxiliary to the Medical and Chirurgical Faculty pays one hundred dollars yearly to the Medical and Chirurgical Faculty towards clerical expenses incurred in its behalf at the Faculty Building. We are sorry that at present we can afford only this token payment and wish to express our thanks to both the Medical Society and its wonderful staff who have worked so hard to help us.

GOOD PUBLIC RELATIONS

MRS. A. S. CHALFANT, *Chairman*, Public Relations Committee

In his opening address at the recent Clinical Conference of the A.M.A. the President, Dr. John W. Cline, said, "The next year will be one of important decision. If we are to protect our heritage of freedom—this decision must be correct—it may not be easy to stop the progress toward socialism, but it is far easier to halt it now than to try to eliminate it after it has become an accomplished fact—the history of other nations clearly demonstrates that beyond a certain point there is no easy way of return—should this country continue on the road that leads to socialism, those things which we cherish will be irrevocably lost."

At the Public Relations Conference of the A.M.A. in December, Dr. Louis Bauer, the President-Elect, said in his keynote address, "The defeat of socialism must be accomplished at the community level because national opinion is the sum total of the public attitude of local communities." According to Dr. Bauer, "the tide can be turned in 1952, but we must *work* together to do it."

How can the Maryland Auxiliary help doctors educate the public to the fact that "your doctor's primary concern is to provide the finest medical care in the world"? One way is to make sure that the public, as well as the physicians, have access to information about our medical organizations, their services, their purposes and their goals. These organizations are not, of course, self-seeking unions, but exist to help doctors become better doctors, and to thus provide better medical service to our people. They are self-disciplining groups and as such most of them have "Grievance Committees," or "Professional Ethics Committees" to which the public may appeal. The Public Relations Department of the A.M.A. suggests as a means of reducing public complaints: the discussion of fees in advance, explanation of extras (consultant's fees, etc.), itemized bills, budgetary help to patients for long-term medical care, the announcement that medical care is available, regardless of ability to pay, promotion of voluntary insurance and informing patients of the availability of catastrophic insurance plans, and the acknowledgment of complaints so that the patient knows the wheels of justice are turning. Another way is to thoroughly publicize your night call and emergency system. Also, the Auxiliary might send a card to all newcomers in the community listing the available medical services!

We can consciously develop better relations with the press and radio. We can see that our local newspapers are invited to or informed of our important meetings and projects. They are glad to publish items of local interest.

Auxiliary members, as well as doctors, should take a properly active role in various health campaigns and civic betterment projects. Those, who would socialize medicine, state that the doctors are a self-centered lot. We know that our doctors and their families are in the vanguard of every worth-while civic undertaking. See that this active community participation is properly recognized by the press!

Strengthen your Auxiliary by working to increase its membership. Educate your new members in Good Public Relations and put them to work promptly.

Plan now for your booth or tent at your County Fair. Your Medical Society will help and advise you. Perhaps your local National Guard will lend you a tent as a public service. Write to the A.M.A. for exhibits which illustrate the ways in which its services protect the health of the American people. You could make an exhibit of the services your State and local Medical Societies render. You would probably be surprised yourself at how many and how varied they are!

Another interesting study might be made of "What constitutes a *GOOD PATIENT*." This could well be based on your own experience as a doctor's wife similar to those related by Dr. Robert K. Webster, (Brazil, Indiana) in the Saturday Evening Post of November 17, 1951—"I'm a Doctor and I'm Human!"

If you will concern yourself with the wives of the young student doctors, who may or may not be members of the Junior A.M.A., you will help assure the future of your Auxiliary. They have problems and need the encouragement and interest of those who have had similar experiences. Always invite them to your meetings as guests of the Auxiliary.

Sometimes Public Relations opportunity comes from unexpected sources. Do not let them slip by you. Remember, your aim is to let people know that "your doctor's primary concern is to provide the finest medical care in the world."

AUXILIARY NURSING SCHOLARSHIPS

We are extremely proud to announce that nursing scholarships are either established or are in process of being set-up by the Auxiliaries to the Baltimore County, Prince George's County, Montgomery County, and Washington County Medical Societies! Baltimore County which scored a "first" by founding the first Auxiliary sponsored nursing scholarship in Maryland now has its second protégé starting in training! This is a wonderful way to help ease the nursing shortage and also to help a fellow human being attain a professional career.

DOCTORS' WIVES, BE INFORMED!

MRS. OMAR D. SPRECHER, Jr., *"Bulletin" Chairman*[1]

Pardon me, were you just passing through? It is so nice to meet a woman in the middle of a man's magazine. I did hope some of the women would get to this page. I've been waiting to visit a little with you.

"An informed Auxiliary is an efficient Auxiliary." Now there, you must remember where we've met before. Of course I'm your Bulletin Chairman. I gave a short talk at the last Auxiliary meeting on why we should subscribe and read the Bulletin of the Woman's Auxiliary to the American Medical Association. You had to leave the meeting a little early and I didn't get your subscription. I did call you on the phone but always seemed to just miss you. I really wanted to tell you why I think you should subscribe to our Bulletin.

First, our motto for 1952 is "An informed Auxiliary is an efficient Auxiliary." Next I find that today Auxiliary leaders are saying "The improved Bulletin has been a revelation to me—I look forward to the receipt of each issue so that I can read and study our officers reports, and keep abreast of Auxiliary progress. I find it invaluable for my files and future references."

Why not slip one of those "fifty cent" dollars to your Bulletin Chairman today? Tomorrow you will have forgotten the expenditure, but the pleasure of receiving the Bulletin will last for one year.

MEDICAL RESEARCH EDUCATION

Our Chairman of Medical Research, Mrs. R. Walter Graham, Jr., hopes that the Auxiliary will place the speakers, movies, and exhibits offered by the Maryland Society for Medical Research, wherever we can before groups; in schools, and at the County Fair "Health Booths," this summer! In this way we can educate people to the needs of research. Our job is to secure an audience for the very fine program outlined below by Dr. Dietrich C. Smith, secretary of the Maryland Society for Medical Research! (Society Headquarters are at 29 S. Greene Street, Baltimore 1, Maryland.)

THE PROGRAM OF THE MARYLAND SOCIETY FOR MEDICAL RESEARCH

DIETRICH C. SMITH, PH.D.[2]

Your Auxiliary is cooperating with the Maryland Society for Medical Research! The educational program of this Society is designed to acquaint the people of Maryland with the cost, needs and goals of medical research as carried out in this State and elsewhere. It emphasizes the fact that the public can most effectively support medical research by supporting the medical schools and that it is only by fostering fundamental research, that applied research will continue to give mankind new drugs, new treatments and new surgical techniques. To this end the medical schools and research institutions must be supplied with proper tools in the form of adequate funds, equipment, personnel and animals.

[1] Bulletin Chairman for the Bulletin of the Woman's Auxiliary to the A.M.A.

[2] Professor of Physiology, School of Medicine, The University of Maryland.

To achieve these goals the Maryland Society for Medical Research has adopted a program of supplying qualified speakers on the various facts of medical research for meetings of clubs, societies, schools, churches, and other civic organizations. It also supplies speakers for vocational guidance groups in the schools and colleges outlining the careers and opportunities open in medical research. The Society arranges conducted tours through the laboratories in Baltimore of selected groups of students from science classes and clubs.

In addition, it publishes a quarterly Bulletin describing the activities of the Society to its members and other interested persons. It has produced and exhibits a motion picture film entitled, "Frontiers in Medical Research," showing the medical research institutions in Baltimore, the kind of animals they use and some of the research procedures. Other motion picture films dealing with various aspects of medical research are also available.

The Society is supported by dues and contributions of its members who are drawn from all walks of life throughout the City and State. It is not a fund raising organization and does not propose to conduct or sponsor any fund raising campaign among the general public! It *is* prepared at any time to fight actively for any legislation that will further its goals and is equally well prepared to fight against any legislation that it believes will hinder the advancement of medical research.

NEW EFFORT UNDER WAY TO GET PRIORITY I PHYSICIANS TO JOIN RESERVES

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

A new effort is being made to induce about 1,000 physicians rated in Priority I of the doctor-draft to sign up for service in the military reserves. Men involved were educated at government expense during World War II or deferred from service to continue their medical educations, but so far have not applied for reserve commissions.

National Advisory Committee to Selective Service (Dr. Howard A. Rusk, Chairman) declares: "Various state committees, as well as the National Committee, have been deeply concerned over these individuals who did not at the time of special registration apply for a commission and have not subsequently done so *while other more willing individuals have accepted commissions and many of them are now serving in the armed forces.*"

Selective Service Director Louis B. Hershey says these "inequities" can only be prevented by calling up physicians through Selective Service (not the reserves).

The acting chairman of *Defense Department's Medical Policy Council*, Dr. Melvin A. Casberg, warns: "When all Priority I type reserves have been called to active duty . . . the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called. *It is anticipated this will occur within the next six months.* Hence, the recalcitrant ones are only delaying their service until all Priority I registrants who have accepted commissions are called up."

Meanwhile, Defense Department has announced that 290 medical reserve officers will be called to active duty in July. Included will be 135 physicians. All are Priority I type reserves and will serve for two years.

MARYLAND SOCIETY FOR MEDICAL RESEARCH

DIETRICH C. SMITH, PH.D.[1]

The Maryland Society for Medical Research is now in its second year as an active working organization dedicated to informing the people of the State concerning the needs of its medical research institutions. It is actively seeking new members and hopes to enroll all of the physicians in the State. An exhibit describing the work of the Society will be on display at the forthcoming meeting of the Medical and Chirurgical Faculty at the Faculty Building in Baltimore April 28–30. The Society depends entirely upon dues and contributions from its members to carry on its work.

The Society was incorporated in 1950 and during the first year of its existence organized the opposition to the antivivisectionist-sponsored amendment to the City Charter forbidding the use of impounded dogs for experimental purpose by the research institutions in Baltimore City, and establishing a so-called Humane Commission with the power to investigate the use of animals in medical research. With the help of thousands of public spirited citizens it brought this amendment down to ignominious defeat, the 4 to 1 vote against the amendment in Baltimore being the highest ever obtained by the friends of medical research on this issue at any election in the country.

With this victory behind it the Society had no intention of resting on its laurels, but instead turned its attention to implementing its long-term educational program and has been quietly working on this objective ever since. Among the many activities it has sponsored, are conducted tours through some of the local research laboratories, for science classes and clubs from the high schools in the immediate area and vocational guidance programs explaining the opportunities open in medical fields to groups in the public schools. It also maintains a speaker's bureau which will supply any interested organization with a speaker on any topic related to medical research. A Bulletin is published quarterly giving news in regard to the various activities the Society sponsors and encourages, as well as news concerning the progress of similar organizations throughout the country. The recent passage of a bill by the New York Assembly, after a long and bitter fight, permitting medical schools in that state to have access to impounded dogs is reminiscent of the struggle in Baltimore and is a heartening sign that an understanding of the issues involved is spreading among the general public. It also underlines the necessity for continuing educational work so that gains here and elsewhere will be held.

One of the more ambitious projects undertaken by the Society during the past year is the production of a motion picture film entitled "Frontiers in Medical Research" in color and sound. This film is now complete and available for showing to any interested group on request to the Society's headquarters, 522 West Lombard St., Baltimore 1, MUlberry 5348. The picture runs for twenty-five minutes and shows scenes, both exterior and interior, of the various medical research institutions throughout the City; the types of animals used in experimental work and some of the more common laboratory procedures employed. The use of anaesthetics in animal research is especially stressed, as is the care and feeding of the animals in the kennels of the various local research institutions.

The Society is particularly anxious to show this film before as many groups throughout the State as possible. Any physician in any community who is asked to organize a medical program for local civic, church or school group and who wishes help or assistance should feel free to call upon the Society. The Society would welcome the opportunity to arrange for the exhibition of its film, or to arrange for any other type of program within the scope of its activities for non-professional groups.

[1] Professor of Physiology, University of Maryland School of Medicine; Secretary, Maryland Society for Medical Research, Inc.

Component Medical Societies

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D., *Chairman* EDWARD I. LEDERMAN, M.D., *Secretary*

Monday, May 5, 1952, 8:30 p.m.

Current Trends in the Practice of Anesthesiology. Edward B. Tuohy, M.D., Past President of the American Society of Anesthesiologists, Inc.; Professor of Anesthesiology, Georgetown University School of Medicine, Washington, D. C. (By invitation.)

RADIOLOGICAL SECTION

J. HOWARD FRANZ, M.D., *Chairman* RICHARD B. HANCHETT, M.D., *Secretary*

Tuesday, May 20, 1952, 8:30 p.m.

Brief meeting for conclusion of annual business.
Election of officers.

ORTHOPAEDIC SECTION

JESSE N. BORDEN, M.D., *Chairman* EDMOND J. MCDONNELL, M.D., *Secretary*

Monday, May 26, 1952

Program, time and place to be announced.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Chairman*

JOINT MEETING WITH THE MARYLAND SOCIETY OF PATHOLOGISTS, INC.

This meeting will be held at the National Cancer Institute, Bethesda, Maryland.
Program and date to be announced.

ROYALTIES FOR AMERICAN MEDICAL EDUCATION FOUNDATION

Secretary's Letter No. 209, February 18, 1952

A. M. A. President John W. Cline said the A. M. A. Board of Trustees had approved in principle a plan whereby the A. M. A., as a corporation, would accept patents for medical discoveries made by member physicians. All Royalties, he said, would be turned over to the *American Medical Education Foundation* for distribution to medical schools.

MARYLAND ACADEMY OF GENERAL PRACTICE

Hotel Alexander, Hagerstown, Maryland

Thursday, May 15, 1952

PRELIMINARY ANNOUNCEMENT AND PROGRAM

10:00 a.m. to 12:00 noon

Registration and technical exhibits.
Medical film in color and sound:

1. Urinary tract infections—time 35 min.
2. Cervicitis—time 50 min.
3. Anti-coagulant therapy—time 32 min.

12:00 noon to 1:00 p.m.

Completion of registration, informal luncheon. (Luncheon not included in registration fee.)

1:00 p.m. to 5:00 p.m.

ON CARCINOMA PRESENTED BY PROMINENT MEMBERS OF THE FACULTY OF THE UNIVERSITY OF PENNSYLVANIA UNDER THE DIRECTION OF DOCTOR I. S. RAVDIN.

1:00 p.m. to 2:00 p.m.

Carcinoma of the Thyroid.
Dr. Robert C. Horn
Dr. Richard H. Chamberlain
Dr. I. S. Ravdin or Dr. William T. Fitts, Jr.

2:00 p.m. to 3:00 p.m.

Carcinoma of the Colon.
Dr. Thomas E. Machella
Dr. Richard H. Chamberlain
Dr. William T. Fitts, Jr.

3:00 p.m. to 4:00 p.m.

Carcinoma of the Pelvic Organs.
Dr. Franklin L. Payne
Dr. Douglas P. Murphy
Dr. Robert C. Horn, Jr.

4:00 p.m. to 5:00 p.m.

Carcinoma of the Lung.
Dr. Richard H. Chamberlain
Dr. Joseph F. Atkins
Dr. Julian Johnson

5:30 p.m. to 6:00 p.m.

Cocktails at the Hotel Alexander.

6:30 p.m.

Banquet, Hotel Alexander. The name of the speaker will be announced later. Paper will be on a non-technical subject.

LADIES AFTERNOON PROGRAM: Arrangements are being made for entertainment of the ladies attending at the Country Club; plans include luncheon and a diverse program.

REGISTRATION FEES:

Scientific session only	$3.00
Scientific session, cocktails, banquet	$7.00
Ladies luncheon and afternoon program	$1.50
Ladies attending cocktail party and banquet	$4.00

There will be no fee for attendance at the scientific session for wives of physicians attending, medical students, interns, residents and members of the allied professions.

For further information write to Dr. William T. Layman, Hagerstown, Maryland.

THE MARYLAND SOCIETY FOR MEDICAL RESEARCH NEEDS YOUR SUPPORT

VISIT THE EXHIBIT AND ENROLL AS A MEMBER

AT THE ANNUAL MEETING IN BALTIMORE

APRIL 28–29–30

EXCERPTS FROM CAPITOL CLINICS, A. M. A.

NATIONAL ADVISORY COMMITTEE CAUTIONS HOSPITALS ON SELECTING RESIDENTS

Capitol Clinic, A. M. A., Vol. 3, No. 6, February 12, 1952

National Advisory Committee to Selective Service advises hospitals to attempt to select their residents for 1952–53 *in the reverse order of their priority under the Doctor-Draft law*, with none chosen from Priority I "except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital." The Committee also reiterates that information on registrants, submitted for the purpose of reopening their cases, must come from the *chairman in the state* in which the individual is engaged in his professional activities and must be addressed to the man's local Selective Service Board. The National Committee explained that information on the registrant should come from the *state chairman* rather than the *local committee* where he is located to avoid "putting one hospital out of line" with the other hospitals in the affected city.

MRS. ROSENBERG SAYS DEPENDENTS OF SERVICEMEN ARE GETTING LESS MEDICAL CARE

Capitol Clinic, A. M. A., Vol. 3, No. 5, February 5, 1952

Testifying in favor of the military pay raise bill, Assistant Defense Secrtary Anna Rosenberg said the military services currently are able to give medical care to *fewer dependents* than in past years. She gave this as one reason why a pay increase is justified.

Technically, medical care is authorized for dependents *only when professional personnel and facilities are "available."* Mrs. Rosenberg explained that the present situation had developed because of (a) increasing numbers of military personnel who have first claim to medical care, (b) shortages of professional personnel and facilities, particularly hospital beds, and (c) the necessity for keeping large numbers of beds ready for Korean casualties.

Also, Mrs. Rosenberg said the military departments' medical budgets were so low as to leave little money to provide care for wives, children and other dependents. For fiscal 1953, she declared, military departments were budgeted at an average of $120 or less for each uniformed member for a year's medical care (Army $107, Navy $120 and Air Force $117). Construction and maintenance costs of hospitals are not included in the totals.

HOUSE COMMITTEE CUTS VA MEDICAL BUDGET

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

House Appropriations Committee has cut Veterans Administration administrative and medical budget for fiscal 1953 by $91.5 million—$20 million less than budgeted for purchase of drugs and medicines, $4 million less for medical and dental fees which the Committee says are "too high," and $1.5 million cut in alteration and repair funds.

SENATE HEALTH SUBCOMMITTEE ACTION ON EMIC BILLS PROMISED 'FAIRLY SOON'

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

Chairman Lehman (D., N. Y.) of Senate Health subcommittee looks for action "fairly soon" on bills providing *medical, nursing and hospital care for mothers and infants of servicemen in the seven lowest pay grades*. He made the statement at close of hearings on bills sponsored by himself and Senator Humphrey (D., Minn.). Lehman bill also would provide hospitalization for dependents.

Most witnesses supported one or both bills and Children's Bureau estimated that 200,000 babies will be born yearly to wives of enlisted men. Defense Department and Bureau witnesses agreed that between 75,000 and 80,000 of these cases could be handled in military hospitals. Accepting the figure of 200,000, *the question is: how many of the remaining 120,000–125,000 cases cannot be handled by existing facilities, public and private?*

A. M. A. witnesses, opposing both bills, maintained that need for an EMIC program has not been demonstrated. (Text of testimony by Dr. Martha Eliot, Children's Bureau chief, appeared in SPECIAL BULLETIN No. 11; texts of A. M. A. witnesses in SPECIAL BULLETIN No. 12 and summary of testimony of all witnesses will appear in SPECIAL BULLETIN No. 13.)

ONLY FOUR 'CRITICAL TARGET' STATES NOT ACTIVE IN CD MEDICAL STOCKPILING

Capitol Clinic, A. M. A., Vol. 3, No. 7, February 19, 1952

Federal Civil Defense Administration's medical supply stockpiling program now is moving ahead after a year of delays, mostly due to reluctance of some states to appropriate matching money. As late as December 1, CDA reported that 15 states containing critical target areas had not yet entered the program. Within the last two months, however, *all but four of these either submitted acceptable plans to Washington or are busy working out plans*. The funds, matched by states, will be spent for emergency medical supplies, to be stockpiled locally for use immediately after an attack.

CDA disclosed that the situation was changing for the good in announcing allocation of more than $8 million to 14 states for local medical stockpiles, including such items as burn dressings, litters, blood plasma, antibiotics and surgical instruments.

States already participating in the program, with total budgets for each are:

California	$3,984,638	Maryland	$ 398,231	Oregon	$ 15,504
Colorado	39,632	Massachusetts	298,674	Rhode Is.	3,766
Connecticut	303,903	Michigan	793,707	Tennessee	197,430
Delaware	50,275	New Jersey	552,360	Washington	498,666
Kansas	97,549	New York	9,486,896		

Although states are paying half the costs, most of the funds will be expended through CDA, to take advantage of bulk purchasing while at the same time not exceeding the capacity of manufacturers. Federal Civil Defense Administration also has about $33 million available for setting up and maintaining regional warehouses for medical supplies. These stocks, *paid for entirely by U. S.*, will be held in reserve, to be rushed in to an attacked area to supplement local supplies after the first few hours.

THE FACULTY BUILDING WILL BE CLOSED MEMORIAL DAY, FRIDAY, MAY 30, 1952